

National Patient Safety Goals Effective January 2021 for the Nursing Care Center Program

Goal 1

Improve the accuracy of patient and resident identification.

NPSG.01.01.01

Use at least two patient or resident identifiers when providing care, treatment, and services.

Note: At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician knows the patient or resident, one identifier can be facial recognition.

--Rationale for NPSG.01.01.01--

Wrong-patient or wrong-resident errors can occur in virtually all stages of diagnosis and treatment. The intent of this goal is two-fold: first, to reliably identify the patient or resident as the person for whom the service or treatment is intended; second, to match the service or treatment to that patient or resident. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.

Element(s) of Performance for NPSG.01.01.01

1. Use at least two patient or resident identifiers when administering medications; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's or resident's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 7 and 10)
2. Label containers used for blood and other specimens in the presence of the patient or resident.

Goal 3

Improve the safety of using medications.

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NPSG.03.05.01

Reduce the likelihood of harm to patients and residents associated with the use of anticoagulant therapy.

Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).

--Rationale for NPSG.03.05.01--

Anticoagulation therapy can be used as therapeutic treatment for several conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulant medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient or resident compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients and residents on this class of medications, including improving patient and resident outcomes.

To achieve better patient and resident outcomes, patient and resident education is a vital component of an anticoagulation therapy program. Effective anticoagulation education includes face-to-face interaction with a trained professional who works closely with patients and residents to be sure that they understand the risks involved with anticoagulation therapy and the precautions they need to take. The use of standardized practices for anticoagulation therapy that include patient and resident involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, warfarin, and direct oral anticoagulants (DOACs).

Element(s) of Performance for NPSG.03.05.01

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| 1. | The organization uses approved protocols and evidence-based practice guidelines for the initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug–drug and drug–food interactions; and other risk factors as applicable. | R <input type="checkbox"/> |
| 2. | The organization uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication. | R <input type="checkbox"/> |
| 4. | The organization has a written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy.
Note: For all patients or residents receiving warfarin therapy, use a current international normalized ratio (INR) to monitor and adjust dosage. For patients or residents on a direct oral anticoagulant (DOAC), follow evidence-based practice guidelines regarding the need for laboratory testing. | R <input checked="" type="checkbox"/> |
| 5. | The organization addresses anticoagulation safety practices through the following:
- Establishing a process to identify, respond to, and report adverse drug events, including adverse drug event outcomes
- Evaluating anticoagulation safety practices, taking actions to improve safety practices, and measuring the effectiveness of those actions in a time frame determined by the organization | R <input type="checkbox"/> |
| 6. | The organization provides education to patients, residents, and families specific to the anticoagulant medication prescribed, including the following:
- Adherence to medication dose and schedule
- Importance of follow-up appointments and laboratory testing (if applicable)
- Potential drug–drug and drug–food interactions
- The potential for adverse drug reactions | R <input type="checkbox"/> |
| 7. | The organization uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
Note: For pediatric patients and residents, prefilled syringe products should be used only if specifically designed for children. | R <input type="checkbox"/> |

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8. When heparin is administered intravenously and continuously, the organization uses programmable pumps in order to provide consistent and accurate dosing.



Introduction to Reconciling Medication Information

The large number of people receiving health care who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a clinician compares the medications a patient or resident should be using (and is actually using) to the new medications that are ordered for the patient or resident and resolves any discrepancies.

The Joint Commission recognizes that organizations face challenges with medication reconciliation. The best medication reconciliation requires a complete understanding of what the patient or resident was prescribed and what medications the patient or resident is actually taking. It can be difficult to obtain a complete list from every patient or resident in an initial encounter, and accuracy is dependent on the patient's or resident's ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As health care evolves with the adoption of more sophisticated systems (such as centralized databases for prescribing and collecting medication information), the effectiveness of these processes will grow.

This National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are designed to help organizations reduce negative patient or resident outcomes associated with medication discrepancies. Some aspects of the care process that involve the management of medications are addressed in the standards rather than in this goal. These include coordinating information during transitions in care both within and outside of the organization (PC.02.02.01), patient and resident education on safe medication use (PC.02.03.01), and communications with other providers (PC.04.02.01).

In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide to patients and residents. It is often important for clinicians to know what medications the patient or resident is taking when planning care, treatment, and services, even in situations where medications are not used.

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NPSG.03.06.01

Maintain and communicate accurate patient and resident medication information.

--Rationale for NPSG.03.06.01--

There is evidence that medication discrepancies can affect outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient or resident is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected in order to reconcile current and newly ordered medications and to safely prescribe medications in the future.

Element(s) of Performance for NPSG.03.06.01

1. Obtain information (for example, name, dose, route, frequency, duration, purpose) on the medications the patient or resident is currently taking when he or she is admitted to or accepted into the organization. This information is documented in a list or other format that is useful to those who manage medications.



Note 1: The organization obtains the patient's or resident's medication information when he or she enters the organization. This information is updated when the patient's or resident's medications change, for example, after treatment in another setting, such as a hospital or physician's office.

Note 2: Current medications include those taken at scheduled times and on an as-needed basis. See the Glossary for a definition of medications. Contact the prescriber with any concerns about specific medications. (See also MM.05.01.01, EP 11)

Note 3: It is often difficult to obtain complete information on current medications from a patient or resident. A good faith effort to obtain this information from a patient or resident and/or other sources will be considered as meeting the intent of the EP.

3. Compare the medication information the patient or resident brought to the organization with the medications ordered for the patient or resident by the organization in order to identify and resolve discrepancies.



Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)

4. Provide the patient or resident (or family as needed) with written information on the medications the patient or resident should be taking when he or she leaves the organization's care (for example, name, dose, route, frequency, duration, purpose).



5. Explain the importance of managing medication information to the patient or resident when he or she leaves the organization's care.



Note: Examples include instructing the patient or resident to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on medication education, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

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Goal 7

Reduce the risk of health care–associated infections.

NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the current World Health Organization (WHO) hand hygiene guidelines.

--Rationale for NPSG.07.01.01--

According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization. Consequently, health care–associated infections (HAIs) are a patient and resident safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients and residents, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, monitors compliance, and provides feedback.

Element(s) of Performance for NPSG.07.01.01

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| 1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Set goals for improving compliance with hand hygiene guidelines. | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Improve compliance with hand hygiene guidelines based on established goals. | <input type="checkbox"/> <input type="checkbox"/> |

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Goal 9

Reduce the risk of patient and resident harm resulting from falls.

NPSG.09.02.01

Reduce the risk of falls.

--Rationale for NPSG.09.02.01--

Falls account for a significant portion of injuries in hospitalized patients, nursing care center patients and 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 or resident'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 or resident'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.

Element(s) of Performance for NPSG.09.02.01

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| 1. Assess the patient's or resident's risk for falls. | <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 2. Implement interventions to reduce falls based on the patient's or resident's assessed risk. | <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 3. Educate staff on the fall reduction program in time frames determined by the organization. | <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 4. Educate the patient or resident and, as needed, the family on any individualized fall reduction strategies. | <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 5. Evaluate the effectiveness of all fall reduction activities, including assessment, interventions, and education. | <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> |
- Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number of falls with injuries.

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Goal 14

Prevent health care–associated pressure injuries.

NPSG.14.01.01

Assess and periodically reassess each patient’s and resident’s risk for developing a pressure injury and take action to address any identified risks.

--Rationale for NPSG.14.01.01--

Pressure ulcers (decubiti) continue to be problematic in all health 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 patients and residents at risk and define early intervention for prevention of pressure ulcers.

Element(s) of Performance for NPSG.14.01.01

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| 1. Create a written plan for the identification of risk for and prevention of pressure injuries. | <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> |
| 2. Perform an initial assessment at admission to identify patients and residents at risk for pressure injuries. | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 3. Conduct a systematic risk assessment for pressure injuries using a validated risk assessment tool such as the Braden Scale or Norton Scale. | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 4. Reassess pressure injury risk at intervals defined by the organization. | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 5. Take action to address any identified risks to the patient or resident for pressure injuries, including the following:
- Preventing injury to patients and residents by maintaining and improving tissue tolerance to pressure in order to prevent injury
- Protecting against the adverse effects of external mechanical forces | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 6. Educate staff on how to identify risk for and prevent pressure injuries. | <input checked="" type="checkbox"/> <input type="checkbox"/> |