National Patient Safety Goals Effective January 1, 2016

Nursing Care Center Accreditation 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.

Elements 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 8 and 11) | R | C | | Ⓜ | △3

2. Label containers used for blood and other specimens in the presence of the patient or resident. | R | A | | | △3

Goal 3
Improve the safety of using medications.

NPSG.03.05.01

Reduce the likelihood of harm to patients and residents associated with the use of anticoagulant therapy.
Note: This requirement applies only to organizations that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's or resident'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 or resident's laboratory values for coagulation will remain within, or close to, normal values.

--Rationale for NPSG.03.05.01--

Anticoagulation therapy can be used as therapeutic treatment for a number of 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 anticoagulation 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 and result in better 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, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. 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, and warfarin.

Elements of Performance for NPSG.03.05.01

1. Use 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 A △3

2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.
   R C Ⓜ △3

3. Before starting a patient or resident on warfarin, assess the patient's or resident's baseline coagulation status; for all patients and residents receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the clinical record.
   Note: The patient's or resident's baseline coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors.
   R A △3

4. Use authoritative resources to manage potential food and drug interactions for patients and residents receiving warfarin.
   R A △3

5. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.
   R A △3

6. A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.
   R A Ⓓ △3

7. Provide education regarding anticoagulant therapy to prescribers, staff, patients, residents, and families. Patient/resident/family education includes the following:
   - The importance of follow-up monitoring
   - Compliance
   - Drug-food interactions
   - The potential for adverse drug reactions and interactions
   R C Ⓜ △3

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8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.

R	A		

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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. A new requirement in this NPSG addresses the role of patients and residents in medication safety: it requires organizations to inform the patient or resident about the importance of maintaining updated medication information.

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 (and 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 to reconcile current and newly ordered medications and to safely prescribe medications in the future.

Elements 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.

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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)

R **C** Ⓜ △3

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). For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.

R **C** Ⓓ Ⓜ △3

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.)

R **C** Ⓜ △3

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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 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, and monitors compliance and provides feedback.

Elements of Performance for NPSG.07.01.01

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. **R** A △3

2. Set goals for improving compliance with hand hygiene guidelines. **R** A

3. Improve compliance with hand hygiene guidelines based on established goals. **R** A

NPSG.07.04.01

Implement evidence-based practices to prevent central line–associated bloodstream infections.
Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

Elements of Performance for NPSG.07.04.01

1. Educate staff and licensed independent practitioners who are involved in managing central lines about 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. **R** C Ⓜ

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. **R** C Ⓓ Ⓜ △3

13. Evaluate all central venous catheters routinely and remove nonessential catheters. **R** C Ⓜ △3

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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.

Elements of Performance for NPSG.09.02.01

#	Element				
1.	Assess the patient's or resident's risk for falls.	R	C	Ⓜ	⚠3
2.	Implement interventions to reduce falls based on the patient's or resident's assessed risk.	R	A		⚠3
3.	Educate staff on the fall reduction program in time frames determined by the organization.	R	C	Ⓜ	
4.	Educate the patient or resident and, as needed, the family on any individualized fall reduction strategies.	R	C	Ⓜ	
5.	Evaluate the effectiveness of all fall reduction activities, including assessment, interventions, and education. Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number and severity of fall-related injuries.	R	A		

Goal 14

Prevent health care–associated pressure ulcers (decubitus ulcers).

NPSG.14.01.01

Assess and periodically reassess each patient's and resident's risk for developing a pressure 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 patients and residents at risk and define early intervention for prevention of pressure ulcers.

Elements of Performance for NPSG.14.01.01

#	Element				
1.	Create a written plan for the identification of risk for and prevention of pressure ulcers.	R	A	Ⓓ	
2.	Perform an initial assessment at admission to identify patients and residents at risk for pressure ulcers.	R	C	Ⓜ	⚠3
3.	Conduct a systematic risk assessment for pressure ulcers using a validated risk assessment tool such as the Braden Scale or Norton Scale.	R	C	Ⓜ	⚠3
4.	Reassess pressure ulcer risk at intervals defined by the organization.	R	C	Ⓜ	⚠3
5.	Take action to address any identified risks to the patient or resident for pressure ulcers, 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	R	C	Ⓜ	⚠3
6.	Educate staff on how to identify risk for and prevent pressure ulcers.	R	A		

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