

# National Patient Safety Goals®

## Effective January 2025 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 individual providing care 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**

- EP 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, 10)
- EP 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.

#### **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.

# National Patient Safety Goals®

## Effective January 2025 for the Nursing Care Center Program

To achieve better patient and resident outcomes, patient and resident education is a vital component of an anticoagulation therapy program. 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

- EP 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.
- EP 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
- EP 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.
- EP 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 physician or other licensed practitioner 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).

# National Patient Safety Goals®

## Effective January 2025 for the Nursing Care Center Program

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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 physicians or other licensed practitioners to know what medications the patient or resident is taking when planning care, treatment, and services, even in situations where medications are not used.

### 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 physicians or other licensed practitioners 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

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- EP 1 Obtain information (for example, name, dose, route, frequency, duration, purpose) on the medications the patient or resident is currently taking when they are 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 they enter 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.
- 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.
- Ⓧ Documentation is required.
- 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.
- EP 4 Provide the patient or resident (or family as needed) with written information on the medications the patient or resident should be taking when they leave the organization's care (for example, name, dose, route, frequency, duration, purpose).
- Ⓧ Documentation is required.

# National Patient Safety Goals®

## Effective January 2025 for the Nursing Care Center Program

- EP 5 Explain the importance of managing medication information to the patient or resident when they leave the organization's care.

Note: Examples include instructing the patient or resident to give a list to their primary care provider; 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.)

## 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) and/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 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

- EP 1 Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.06.01.01, EP 3)
- EP 2 Set goals for improving compliance with hand hygiene guidelines.
- EP 3 Improve compliance with hand hygiene guidelines based on established goals.

## Goal 9

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

### NPSG.09.02.01

Reduce the risk of falls.

# National Patient Safety Goals®

## Effective January 2025 for the Nursing Care Center Program

### --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

- EP 1 Assess the patient's or resident's risk for falls.
- EP 2 Implement interventions to reduce falls based on the patient's or resident's assessed risk.
- EP 3 Educate staff on the fall reduction program in time frames determined by the organization.
- EP 4 Educate the patient or resident and, as needed, the family on any individualized fall reduction strategies.
- EP 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 of falls with injuries.

## Goal 14

Prevent health care–associated pressure injuries from occurring or worsening.

### NPSG.14.01.01

Assess and periodically reassess each patient's and resident's risk for either developing a pressure injury or worsening of their existing pressure injury. Take action to address any identified risks.

### --Rationale for NPSG.14.01.01--

Pressure injuries continue to be problematic in all health care settings. Most pressure injuries 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 injuries.

### Element(s) of performance for NPSG.14.01.01

- EP 1 Create a written plan for risk identification, prevention, and treatment of pressure injuries based on clinical practice guidelines and evidence-based practices.
  - ⓓ Documentation is required.
- EP 2 Perform an initial systematic assessment at admission to identify patients and residents at risk for pressure injuries. Risk assessment tools such as the Braden Scale or the Norton Scale should be used in conjunction with a clinical assessment.

# National Patient Safety Goals®

## Effective January 2025 for the Nursing Care Center Program

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EP 3 When a pressure injury is diagnosed, treatment to stop the progression of the wound should be immediate and align with best practices. Documentation must include prevention methods, treatment plans, wound measurements, description of any exudate, wound stage, and photographic imaging when available.

Note: The National Pressure Ulcer Advisory Panel clinical practice guidelines are an evidence-based resource.

EP 4 Reassess pressure injury risk or wound condition at intervals defined by the organization or as ordered by a physician or other licensed practitioner.

EP 5 Take action to address any identified risks to the patient or resident for pressure injuries, including the following:

- Prevent injury to patients and residents by maintaining and improving tissue tolerance
- Keep skin clean and dry
- Prevent friction and shear
- Protect against the adverse effects of external mechanical forces

EP 6 Staff receive initial and ongoing education, according to time frames determined by the organization, on how to identify risk for and prevent pressure injuries.

EP 7 Staff receive training, according to time frames determined by the organization, on identifying the signs of a new pressure injury and the immediate actions to take prior to providing care, treatment, and services.

Ⓧ Documentation is required.

EP 8 Physicians and other licensed practitioners receive ongoing training on pressure injury risk identification, prevention protocols, staging, and documentation.

Ⓧ Documentation is required.

EP 9 Patients, residents, and families receive education about pressure injury prevention.

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