The Joint Commission

National Patient Safety Goals Effective January 1, 2016

Behavioral Health Care Accreditation Program

Goal 1

Improve the accuracy of the identification of individuals served.

NPSG.01.01.01

Use at least two identifiers when providing care, treatment, or services.
Note: Treatments covered by this goal include high-risk interventions and certain high risk medications (for example, methadone). In some settings, use of visual recognition as an identifier is acceptable. Such settings include those that regularly serve an individual (for example, therapy) or serve only a few individuals (for example, a group home). These are settings in which the individual stays for an extended period of time, staff and populations served are stable, and individuals receiving care are well-known to staff.

--Rationale for NPSG.01.01.01--

Errors involved in misidentification of the individual served can 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. 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 identifiers of the individual served when administering medications or collecting specimens for clinical testing. The room number or physical location of the individual served is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11) — R C M 3
2. Label containers used for specimens in the presence of the individual served. — R A 3

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Goal 3

Improve the safety of using medications.

Introduction to Reconciling Medication Information

The large number of people receiving care, treatment, or services 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 the individual served should be using (and is actually using) to the new medications that are ordered for the individual 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 individual served was prescribed and what medications he or she is actually taking. It can be difficult to obtain a complete list from every individual in an encounter, and accuracy is dependent on the ability and willingness of the individual served to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As more sophisticated systems evolve (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 outcomes associated with medication discrepancies. Some aspects of the care, treatment, or services 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 (CTS.04.01.01), education of the individual on safe medication use (CTS.04.01.03), and communications with other providers (CTS.06.02.05).

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. It is often important for clinicians to know what medications the individual is taking when planning care, treatment, or services, even in situations where medications are not used. A new requirement in this NPSG addresses the individual's role in medication safety: it requires organizations to inform the individual served about the importance of maintaining updated medication information.

NPSG.03.06.01

Maintain and communicate accurate medication information for the individual served.

--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 an individual 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 and/or update information on the medications the individual served is currently taking. This information is documented in a list or other format that is useful to those who manage medications. R C D M 3
   Note 1: The organization obtains the individual's medication information during the first contact. The information is updated when the individual's medications change.
   Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.
   Note 3: It is often difficult to obtain complete information on current medications from the individual served. A good faith effort to obtain this information from the individual and/or other sources will be considered as meeting the intent of the EP.
2. Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non–24-hour settings based on situations of individuals served and characteristics of different settings. R A 3

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3. For organizations that prescribe medications: Compare the medication information the individual served brought to the organization with the medications ordered for the individual by the organization in order to identify and resolve discrepancies.
   Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified staff member, identified by the organization, does the comparison. (See also HRM.01.06.01, EP 1)

   R C M 3

4. For organizations that prescribe medications: Provide the individual served (or family as needed) with written information on the medications the individual should be taking at the end of the encounter (for example, name, dose, route, frequency, purpose).
   Note: When the only additional medications prescribed are for a short duration, the medication information the organization provides includes only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard CTS.06.02.05.

   R C D M 3

5. For organizations that prescribe medications: Explain the importance of managing medication information to the individual served.
   Note: Examples include instructing the individual served 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 education of the individual served, refer to Standard CTS.04.01.03.)

   R C M 3

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.
Note: This standard applies only to organizations that provide physical care.

--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, or services in a health care organization. Consequently, health care–associated infections (HAIs) are a 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 individuals served, 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.

Following safe hand hygiene practices is important in all organizations; however, the risk to individuals served increases when there is physical contact. In these situations, it is more important to follow formal hand hygiene guidelines. This requirement, therefore, applies only to organizations that provide physical care.

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. (See also IC.01.04.01, EP 5)
   Note: This element of performance applies only to organizations that provide physical care.

   R A 3

2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 3)
   Note: This element of performance applies only to organizations that provide physical care.

   R A

3. Improve compliance with hand hygiene guidelines based on established goals.
   Note: This element of performance applies only to organizations that provide physical care.

   R A

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Goal 15

The organization identifies safety risks inherent in the population of the individuals it serves.

NPSG.15.01.01

Identify individuals at risk for suicide.

--Rationale for NPSG.15.01.01--

Suicide of an individual served 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

1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide. R C D M 3
2. Address the immediate safety needs and most appropriate setting for treatment of the individual served. R C M 3
3. When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family. R C M 3

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