

JOINT COMMISSION 2006 NATIONAL PATIENT SAFETY GOALS
IMPLEMENTATION EXPECTATIONS

Goal and Requirement	Rationale and Implementation Expectations	Program Specific Interpretive Guidelines
<p>Goal 1: Improve the accuracy of patient/resident/client identification</p> <p>Requirement 1A: Use at least two patient/resident/client identifiers (neither to be the room number¹) whenever administering medications or blood products²; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures. (Applicable to Ambulatory Care, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery)</p> <p>¹ The room number exclusion does not apply to home care; replace "room number" with "physical location" for ambulatory care and office-based surgery.</p> <p>² "Blood products" does not apply to behavioral health care.</p>	<p>Rationale: Wrong-patient/client/resident 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.</p> <p>Implementation Expectations: 1A - It is the person-specific information that is the "identifier," not the medium on which that information resides. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, photograph or other person-specific identifier. Bar coding that includes two or more person-specific identifiers (not room number) will comply with this requirement.</p>	<p>Long Term Care/Assisted Living/Behavioral Health Care</p> <p>1A - A common approach in these situations is to include the individual's photograph in the clinical record for purposes of visual identification by staff. For residential care settings that may serve only a few individuals, such as a group home, or settings in which the individual may stay for an extended period of time, where there is stability of the staff and client populations, and the individuals receiving care are well-known to the staff providing that care, we would accept that visual recognition and focus the survey of this requirement on the use of two identifiers for high risk interventions—perhaps for certain high-risk medications, like methadone—to ensure "matching" of the treatment to the individual. For high-risk interventions or in settings with less stable staffing and short length of stay, we would expect the "two identifier" requirement to be followed.</p> <p>Home Care</p> <p>1A - In the home care setting, this is much easier and less prone to error than in other settings.</p>

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<p>Requirement 1A: Use at least two patient identifiers (neither to be the patient's location) whenever collecting laboratory samples or administering medications or blood products, and use two identifiers to label sample collection containers in the presence of the patient. Processes are established to maintain samples' identity throughout the pre-analytical, analytical and post-analytical processes. (Applicable to Laboratories)</p> <p>Requirement 1B: Prior to the start of any invasive procedure, conduct a final verification process³ to confirm the correct patient/resident, procedure, site, and availability of appropriate documents⁴. This verification process uses active—not passive—communication techniques.</p>	<p>Implementation Expectations: 1A – Timely and accurate specimen labeling ensures the correct patient identification from collection through result reporting. The two identifiers used to label the specimen are not required to be the same two identifiers used to identify the patient. Neither of the two sample identifiers may be the patient's location. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, photograph or other person-specific identifier. Bar coding that includes two or more person-specific identifiers (not room number) will comply with this requirement.</p> <p>Implementation Expectations: 1B - The "time out," or immediate preoperative/preprocedural pause, must occur in the location where the procedure is to be done (for example, when the patient is on the operating table). The "time out" should involve the entire procedural team which, at</p>	<p>Certainly, at the first encounter, the requirement for two identifiers is appropriate in a literal sense. Thereafter, and in any situation of continuing one-on-one care where the staff "knows" the individual, one of the identifiers can be direct facial recognition. In the home, the correct address (an acceptable identifier when used in conjunction with another person-specific identifier) is also confirmed.</p> <p>Behavioral Health Care 1A - See applicability table. This does not apply to self-administered medication. Procedures refers to medical procedures not psychosocial interventions.</p>
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<p>(Applicable to Assisted Living, Disease-Specific Care Home Care, Long Term Care (Ambulatory, Critical Access Hospital, Hospital and Office Based Surgery: See the Universal Protocol). ³ Add "such as a 'time out'" for home care and long term care. ⁴ Remove "availability of appropriate documents" for home care and long term care.</p> <p>Requirement 1B: Immediately prior to the start of any invasive procedure, conduct a final verification process to confirm the correct patient, procedure, site, and availability of appropriate documents. This verification process uses active—not passive—communication techniques. The patient's identity is re-established if the practitioner leaves the patient's location prior to initiating the procedure. Marking the site is required unless the practitioner is in continuous attendance from the time of the decision to do the procedure and patient consent to the initiation of the procedure (for example, bone marrow collection, or fine needle aspiration).</p>	<p>a minimum, includes the practitioner doing the procedure, the anesthesia provider (if any), and the circulating nurse or other assistant. In addition, there should be no barrier to anyone speaking up if there is a concern about a possible error. "Active" communication, in this context, means an affirmation, orally or by some action that the patient, procedure, and site are correct. Certain routine "minor" procedures such as venipuncture, peripheral IV line placement, insertion of NG tube, or Foley catheter insertion are not within the scope of the Goal. However, most other procedures that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, and endoscopies are within the scope of this Goal. Also see National Patient Safety Goal 4, Requirements 4A and 4B, and the Universal Protocol.</p> <p>Implementation Expectations: 1B – Wrong site, wrong procedure, wrong patient errors can be prevented. The Universal Protocol designed for surgical procedures is intended to achieve that goal by use of a three-pronged approach – using a pre-procedure verification process, marking the procedure site, and conducting a final pre-procedural "time-out". This goal addresses the specific application of the Universal Protocol to invasive procedures performed by the Clinical Laboratory professional.</p>	
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<p>(Applicable to Laboratory)</p> <p>Goal 2: Improve the effectiveness of communication among caregivers.</p> <p>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 order or test result "read-back" the complete order or test result. (Applicable to Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Laboratory, Long Term Care, Office-Based Surgery)</p>	<p>Rationale: 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/client/resident safety.</p> <p>Implementation Expectations: 2A - Simply repeating back the order or test result is not sufficient. Whenever possible, the receiver of the order should write down the complete order or test result or enter it into a computer, then read it back, and receive confirmation from the individual who gave the order or test result. "Critical test results" are defined by the individual health care organization and will typically include "stat" tests, "panic value" reports, and other diagnostic test results that require urgent response.</p>	<p>Ambulatory 2A - Verbal orders given to staff by providers as they move from one patient or activity to another should be discouraged. In emergency situations where it does occur or when delay would impact patient safety, the person receiving the order should write it down and read it back for verification or, at a minimum, "repeat back" the order.</p> <p>Behavioral Health 2A - Please also see setting specific applicability table. Verbal or telephone orders do not include general supervisory instructions or milieu management directions applicable to the entire setting.</p> <p>Home Care 2A - Voicemail orders are not acceptable within the context of the NPSGs. When not received directly,</p>
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<p>Requirement 2B: Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization. (Applicable to Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Laboratory, Long Term Care, Office-Based Surgery)</p>	<p>Implementation Expectations: 2B –An official list of dangerous abbreviations, acronyms, and symbols has been approved by the Joint Commission and must be included on each organization's "Do not use" list. The official list is available at: http://www.jcaho.org/accredited+organizations/patient+safety/dnu.htm. Additional items may be added to an organization's "do not use" list at the organization's discretion.</p> <p>The "do not use" list applies to all orders and other medication-related documentation when handwritten, entered as free text into a computer, or on pre-printed forms. It does not currently apply to computer-generated forms or displays.</p> <p>Trailing zeros may be used in non-medication-related documentation when there is a clear need to demonstrate level of precision, such as for laboratory values, imaging study measurement of lesion sizes, or catheter and therapeutic tube sizes.</p>	<p>the appropriate licensed practitioner must call the prescriber back to get the order directly, including a "read-back."</p> <p>Behavioral Health Care 2B Refer to the setting specific applicability table.</p> <p>Lab 2B Trailing zeros are allowable for use in laboratory data to signify the level of precision, including in handwritten, printed and electronic formats.</p>
<p>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 test results and values. (Applicable to Ambulatory, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care,</p>	<p>Implementation Expectations: 2C & 2D – The organization will need to determine its current turnaround time for reporting. The Joint Commission expects an organization to define the acceptable length of time: a) between the ordering of critical tests and reporting the test results and values, and b) between the availability</p>	<p>Behavioral Health 2C - Please also see setting specific applicability table. Organization needs to define and determine if they receive critical test results.</p> <p>Ambulatory 2C - Assess contract reference laboratories using</p>

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<p>Home Care, Hospital, Laboratory, Office-Based Surgery)</p> <p>Requirement 2D: All values defined as critical by the laboratory are reported to a responsible licensed caregiver within time frames established by the laboratory (defined in cooperation with nursing and medical staff). When the patient's responsible licensed caregiver is not available within the time frames, there is a mechanism to report the critical information to an alternative responsible caregiver. (Applicable to Laboratories)</p> <p>New Requirement 2E: Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions. (Applicable to Ambulatory Health Care, Assisted Living Facility, Behavioral Health Care, Critical Access Hospital, Disease Specific Care, Hospital, Laboratory, Long Term Care, Office Based Surgery and Home Care.)</p>	<p>of critical results/values and receipt by the responsible licensed care giver. The organization then assesses these data, determines whether there is a need for improvement in the timeliness of reporting and, if so, takes appropriate action to improve and measures the effectiveness of those actions.</p> <p>Implementation Expectations: 2D –Critically abnormal results need to be communicated quickly to a responsible individual so that action may be taken. Delays in reporting or responding to a critical value can produce negative patient outcomes. When the responsible licensed caregiver is not available, a back-up reporting system can ensure the information is provided in a timely manner to another qualified responsible caregiver to prevent avoidable delays in treatment or response.</p> <p>Rationale: The primary objective of a "hand off" is to provide accurate information about a patient's/client's/resident'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.</p> <p>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</p>	<p>timeliness expectation criteria outlined in the written contract. Likewise, assess internal reporting against organizational policies relating to timely reporting of critical values for those tests performed in-house.</p>
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<p>Goal 3: Improve the safety of using medications</p>	<p>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.</p> <p>Implementation Expectations: The following are attributes of effective "hand off" communications:</p> <p>Hand offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient/client/resident information.</p> <p>Hand offs include up-to-date information regarding the patient's/client's/resident's care, treatment and services, condition and any recent or anticipated changes.</p> <p>Interruptions during hand offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.</p> <p>Hand offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.</p> <p>The receiver of the hand off information has an opportunity to review relevant patient/client/resident historical data, which may include previous care, treatment and services.</p> <p>Rationale: When medications are part of the</p>	<p>In Behavioral Health organizations that provide twenty-four hour care, treatment or services, a number of hand-offs may occur, such as from teacher to child care worker, at change of shift, or from clinical staff to program staff.</p>
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<p>Requirement 3A: Retired as a NPSG effective January 1, 2006 – see standard MM.2.20 EP 9</p> <p>Requirement 3B: Standardize and limit the number of drug concentrations available in⁶ the organization. (Applicable to Ambulatory, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery) ⁶ Replace “available in” with “used by” for home care.</p>	<p>patient/client/resident treatment plan, appropriate management is critical to ensuring patient/client/resident safety. The development of standardized and redundant systems has been shown to decrease error and improve outcomes.</p> <p>Implementation Expectations: 3B - When more than one concentration is necessary, the number of concentrations should be limited to the minimum if required to meet patient care needs, such as may be the case in pediatrics or neonatal care, and those concentrations should be standardized.</p> <p>The Rule of Six, which results in individualized concentrations, does not meet the requirements of National Patient Safety Goal 3b. However, the Joint Commission will allow for extension of the current exceptions process for use of the Rule of Six through a transition to the expected use of standardized drug concentrations by all providers no later than December 31, 2008. Requests for exceptions will continue to be considered on an organization-by-organization basis and will require ongoing evidence of progress toward full implementation of the use of standardized drug concentrations. The eligibility criteria for participation in the exceptions process during the transition period are as follows:</p> <ul style="list-style-type: none"> • The exception request applies only to the 	<p>Home Care 3B—These apply to medications stored in the home care organization, not to medications already dispensed by a pharmacy to the patient’s residence.</p> <p>Long Term Care 3B - These apply to medications stored in the organization, even medications dispensed by an outside pharmacy to the LTC or ALF.</p> <p>Behavioral Health 3B - Please also see setting specific applicability table. This requirement does not apply to organizations that do not have any drug concentrations</p>
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	<p>neonatal or pediatric acute care services provided by the organization.</p> <ul style="list-style-type: none">• Emergent and nonemergent admixtures are prepared only by pharmacy staff in a sterile environment.• Calculations respecting the drug solutions are validated during the preparation.• The labeling of solution concentrations and drug per milliliter are clear to all caregivers, and the solution concentration (amount of drug per unit volume of solution) is clearly indicated on the label.• If the Rule of 6 is used in a pediatric setting, but standardized drug concentrations are used in other parts of the hospital, guidance aids are made available to caregivers who may not be familiar with one of these systems.• If the organization has a neonatal intensive care unit, the pharmacy is open 24 hours a day to support the admixture service.• Smart pumps are utilized. [A "smart pump" is a parenteral infusion pump equipped with IV medication error-prevention software that alerts operators or interrupts the infusion process when a pump setting is programmed outside of pre-configured limits. Smart pumps are designed to recognize prescription errors, dose misinterpretations, and keypad programming errors.]	
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	<p>Implementation Expectations: Medications include any prescription medications; sample medications; herbal remedies; vitamins; nutraceuticals; over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions (plain, with electrolytes and/or drugs), and any product designated by the Food and Drug Administration (FDA) as a drug. Solutions include chemicals and reagents such as formaline, saline, sterile water, Lugol's solution, radiopaque dyes, glutaraldehyde and chlorhexidine.</p> <p>Medications and solutions both on and off the sterile field should be labeled even if there is only one medication being used.</p> <p>Labeling occurs when any medication or solution is transferred from the original packaging to another container.</p> <p>Labels include drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours. [Revised January 2006]</p> <p>Labels can be developed by the facility or commercially available; sterile labels can be purchased.</p>	
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<p>Goal 4: Eliminate wrong-site, wrong-patient, wrong-procedure surgery. (Ambulatory care, critical access hospitals, hospitals and office-based surgery, refer to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™).</p> <p>Requirement 4A: Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (for example, medical records, imaging studies) are available.</p>	<p>All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication. [Revised January 2006]</p> <p>No more than one medication or solution is labeled at one time.</p> <p>Any medications or solutions found unlabeled are immediately discarded.</p> <p>All original containers from medications or solutions remain available for reference in the perioperative area until the conclusion of the procedure. All labeled containers on the sterile field are discarded at the conclusion of the procedure.</p> <p>At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.</p> <p>Rationale: Wrong-site, wrong-person, wrong-procedure surgery can be prevented if appropriate processes are in place. The intent is to establish and implement processes to always identify the correct site, correct person and correct procedure.</p> <p>Implementation Expectations: 4A - The requirement is for a "preoperative verification process." The checklist is an example of one approach—the most common one. The intent of the</p>	
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<p>(Applicable to Disease-Specific Care)</p> <p>Requirement 4B: Implement a process to mark the surgical site and involve the patient in the marking process.</p> <p>(Applicable to Disease-Specific Care)</p>	<p>requirement is to ensure that all of the relevant documents are <u>available</u> prior to the start of the procedure and that they have been <u>reviewed</u> and <u>consistent</u> with each other and with staffs' understanding of the intended site, patient, and procedure. It is the process that is important.</p> <p>Implementation Expectations: 4B – Marking is required in all cases involving right/left distinction, multiple structures (e.g., fingers, toes), or levels (e.g., spine). Many procedures done through a mid-line orifice are intended to treat an organ that is "right" or "left" and therefore subject to a lateralization error. Similarly, many "open" or endoscopic procedures are done through a mid-line incision or insertion site but are intended to treat an organ that is "right" or "left." Organizations must establish procedures for marking the skin at or near the proposed incision/insertion site to indicate the correct side of the proposed procedure, even when the proposed incision/insertion site is in the mid-line or through a natural body orifice. Site marking is not required if there is an obvious wound or lesion that is the site of the intended procedure. However, if there are multiple wounds or lesions and only some of them are to be treated, and the decision and direction for which ones are to be treated is determined at some time prior to the procedure itself, then the sites to be treated should be marked as soon as possible after the decision is made. The site marking should be done prior to moving the patient into the room where the procedure will be done. The requirement is that the site marking be done "with the involvement of the patient." For this</p>	
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<p>Goal5: Improve the safety of using infusion pumps</p> <p>Requirement 5A Goal 5 and its requirement, 5A have been retired as a NPSG effective January 1, 2006</p> <p>Goal 6: Improve the effectiveness of clinical alarm systems.</p> <p>Requirement 6A: Implement regular preventive maintenance and testing of alarm systems. (Applicable to Disease-Specific Care)</p>	<p>to be done in a meaningful way, it should happen before the patient is sedated and unable to participate. While we require that the patient be involved in the process, it is not expected, or even recommended, that the patient do the marking. If the practitioner performing the procedure remains with the patient continuously from the time the decision is made to do the procedure (and consent is obtained from the patient) up to the time of the procedure itself, then site marking is not required. Dental procedures are exempt from the requirement to mark the site directly, but must mark the operative tooth (teeth) on the dental radiographs or dental diagram.</p> <p>Rationale: Alarm systems are used to alert caregivers to potentially hazardous situations that warrant urgent attention. Once triggered, a consistent and timely response is required to promote patient/client/resident safety. This goal addresses the entire alarm system, from the patient/client/resident to the caregiver, not just the alarm device.</p> <p>Implementation Expectations: 6A - The method and intervals for inspecting, testing, and maintaining clinical alarms should be based on</p>	
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<p>hygiene guidelines (http://www.cdc.gov/handhygiene/).¹⁰ ¹⁰Organizations are required to comply with all IA, IB, and IC CDC recommendations. (Applicable to Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Laboratory, Long Term Care, Office-Based Surgery)</p> <p>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. (Applicable to Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Laboratory, Long Term Care, Office-Based Surgery)</p> <p>Goal 8: Accurately and completely reconcile medications across the continuum of care.</p>	<p>hygiene and should practice it consistently. Implementation of all CDC guidelines with category IA, IB or IC evidence is required. (http://www.cdc.gov/handhygiene/).</p> <p>Implementation Expectations: 7B - A significant percentage of patients/clients/residents 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, why did the patient acquire an infection and, given the fact of the infection, why did the patient die or suffer permanent loss of function?</p> <p>Rationale: Patients/clients/residents 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.</p>	<p>table.</p> <p>BHC 7B Please also see setting specific applicability table</p> <p>Long Term Care/Assisted Living 7B - This determination is based on the condition of the patient at the time of admission to the organization. A death or major permanent loss of function should be considered a SE if the outcome was not the result of the natural course of illness or underlying condition at the time of the admission. If at the time of admission the patient's condition is such that he or she has a high likelihood of not surviving the episode of care, then that patients death would not be considered a SE.</p>
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<p>Requirement 8A: Implement a process for obtaining and documenting a complete list of the patient's/resident's/client 's current medications upon the patient's/resident's/client 's admission¹¹ to the organization and with the involvement of the patient/resident/client. This process includes a comparison of the medications the organization provides to those on the list. (Applicable to Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery) ¹¹ Replace "admission" with "entry" for ambulatory care, behavioral health care and office-based surgery.</p>	<p>Implementation Expectations: 8A - Organizations must implement a standardized method for creating an accurate list of medications at admission/entry and transfer. The list should include the full range of medications as defined in the accreditation manuals:</p> <ul style="list-style-type: none"> • Prescription medications • Sample medications • Vitamins • Nutraceuticals • Over-the-counter drugs • Vaccines • Diagnostic and contrast agents • Radioactive medications • Respiratory therapy-related medications • Parenteral nutrition • Blood derivatives • Intravenous solutions (plain or with additives) • Any product designated by the FDA as a drug <p>Development of a medication reconciliation form, to be used as a template for gathering information about current medications, is one method that can be used to standardize care and prevent errors.</p>	
<p>*Requirement 8B: A complete list of the patient's/resident's/client 's medication is communicated to the next provider of service when a patient/resident/client is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization.</p>	<p>Implementation Expectations: 8B - 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. Thereafter, the next provider of</p>	<p>BHC 8B – Please also see setting specific applicability table. For organizations that do not prescribe medication, the list includes medications as known or reported by the client or guardian.</p>

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<p>(Applicable to Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery)</p> <p>Goal 9: Reduce the risk of patient/resident/client harm resulting from falls.</p> <p>New Requirement 9B: Implement a fall reduction program and evaluate the effectiveness of the program. (Applicable to Assisted Living Facility, Critical Access Hospital, Disease Specific Care, Hospitals, Long Term Care and Home Health.)</p>	<p>service should check over the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.</p> <p>At a minimum, reconciliation must occur any time the organization requires that orders be rewritten and any time the patient changes service, setting, provider or level of care and new medication orders are written. For transitions not involving new medications or rewriting of orders, the organization should determine whether reconciliation must occur.</p> <p>Rationale: 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 assess, its patients'/clients'/residents' risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur.</p> <p>Implementation Expectations: 9B – As appropriate to the population served, the services provided, and the environment of care, a fall reduction program may include risk assessment and periodic reassessment of individual patients'/clients'/residents or of the environment of care. The program should include risk reduction strategies, in-services, involving patients/families in education and environment of care redesign. The program should also include development and</p>	<p>Home Care 9B - Clinical consulting pharmacies and long term care pharmacies would be able to identify medications the patient might be taking for which there would be side effects of drowsiness, motor disturbances, ataxia, etc that would make them prone to falls.</p>
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<p>Goal 10: Reduce the risk of influenza and pneumococcal disease in older adults.</p> <p>Requirement 10A: Develop and implement a protocol for administration and documentation of the flu vaccine. (Applicable to Assisted Living, Disease-Specific Care, Long Term Care)</p> <p>Requirement 10B: Develop and implement a protocol for administration and documentation of the pneumococcus vaccine. (Applicable to Assisted Living, Disease-Specific Care, Long Term Care)</p> <p>Requirement 10C: Develop and implement a protocol to identify new cases of influenza and to manage an outbreak. (Applicable to Assisted Living, Disease-Specific Care, Long Term Care)</p>	<p>implementation of transfer protocols (e.g., bed-to-chair), when relevant.</p> <p>Rationale: 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.</p> <p>Implementation Expectations: 10A & B - Organizations need to develop appropriate protocols for determining whether or not to vaccinate once a person becomes a resident in a long term care or assisted living facility. The Joint Commission does not specify a required format for the documentation related to this requirement. Organizations may choose the documentation method best suited to their structure and current systems.</p> <p>Implementation Expectations: 10C - The organization should continuously monitor the success of their efforts to prevent these diseases by capturing and analyzing data. The performance measures should be reported to the organizational leadership on a regular basis and the organization's performance improvement infrastructure. The data should also be shared with staff, as appropriate, so that they, too, can see how successful they have</p>	
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<p>Goal 11: Reduce the risk of surgical fires.</p> <p>Requirement 11A: Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels, and establish guidelines to minimize oxygen concentration under drapes. (Applicable to Ambulatory and Office-Based Surgery)</p> <p>Goal 12: Implementation of applicable National Patient Safety Goals and associated requirements by components and practitioner sites.</p>	<p>been at reducing the risk of influenza and pneumococcal disease in older patients.</p> <p>Rationale: When surgical fires occur, they often result in serious injury and sometimes death. The unique circumstances in the surgical environment (oxygen-rich atmosphere, flammable materials, and ignition sources) require response and prevention strategies to be specific to the setting. Educating surgical staff to these distinctions is crucial in reducing/eliminating surgical fires.</p> <p>Implementation Expectations: 11A - Guidelines must be established and training of all staff who participate in surgery or other invasive procedures must address ways to minimize oxygen concentration under drapes, avoid the use of flammable solutions and materials, and safely control potential ignition sources. Guidelines and training must also address procedures in response to a surgical fire.</p> <p>Rationale: The purpose of the Joint Commission's National Patient Safety Goals is to promote specific improvements in patient/members/ enrollees safety. The Goals highlight problematic areas in health care and describe evidence and expert-based solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care across the continuum of care, Integrated Delivery Systems, Managed Care Organizations, and Preferred</p>	<p>Ambulatory 11A - Only if applicable. Organizations must determine if they are at risk for surgical fires based on equipment and procedures.</p>
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<p>Requirement 12A: Inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements. (Applicable to Integrated Delivery System, Managed Care Organizations, and Preferred Provider Organizations.)</p>	<p>Provider Organizations are required to promote implementation of these goals by their provider components and practitioners.</p> <p>Implementation Expectations: 12A - Integrated delivery systems, managed care organizations, and preferred provider organizations should assess all of the National Patient Safety Goals and Requirements to see which are applicable to the components and practitioner sites that comprise their network programs. The integrated delivery systems, managed care organizations, and preferred provider organizations should then communicate information on the National Patient Safety Goals and Requirements to their applicable components (ambulatory care, office-based surgery, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, and long term care and practitioner sites) and encourage implementation of the relevant Goals and Requirements. Consideration should be given to incentives for those components and practitioner sites that demonstrate compliance with applicable National Patient Safety Goals.</p>	
<p>New Goal 13: Encourage the active involvement of patients and their families in the patient's own care as a patient safety strategy.</p>	<p>Rationale: Communication with clients/patients and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When clients/patients know what to expect, they are more aware of possible errors and choices. Clients/patients/residents can be an important source of information about potential adverse</p>	

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<p>New Requirement 13A: Define and communicate the means for patients and their families to report concerns about safety, and encourage them to do so. (Applicable to Assisted Living Facility, Disease Specific Care, Laboratory and Home Care.)</p> <p>New Goal 14: Prevent health care-associated pressure ulcers (decubitus ulcers).</p> <p>New Requirement 14 A: Assess and periodically reassess each patient's risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks. (Applicable to Long Term Care)</p>	<p>events and hazardous conditions.</p> <p>Rationale: 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 clinical practice guidelines can effectively identify patients and define early intervention for prevention of pressure ulcers.</p> <p>Implementation Expectations: An effective plan for the prediction, prevention, and early treatment of pressure ulcers includes:</p> <ul style="list-style-type: none"> • Identifying at risk individuals who need prevention 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 	
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	<p>through educational programs.</p> <p>Following are actions for the assessment of residents and prevention of pressure ulcers in adults, and are reflective of the state of current knowledge.</p> <p>Assessment: Prevention of pressure ulcers is dependent on identifying those at risk. A systematic risk assessment can be accomplished by using a validated risk assessment tool such as the Braden Scale or Norton Scale. Pressure ulcer risk should be reassessed at periodic intervals. In LTC, initial assessments are performed at admission. Reassess weekly for the first 4 weeks, then quarterly after that, and whenever the resident's condition changes or deteriorates.</p> <p>Prevention: Preventing pressure ulcers requires a complex interaction of interventions. Interventions include: A plan of care that includes the following:</p> <ul style="list-style-type: none"> • Skin inspection, skin cleansing, care of dry skin, use of moisture barriers and massage. • A plan for nutritional support that meets individual needs • Reducing skin injury from friction and shear forces through use of positioning, transferring and turning techniques. • A plan to increase activity and mobility or 	
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	<p>maintain current level.</p> <ul style="list-style-type: none">• Repositioning, use of repositioning devices and use of mechanical loading and support surfaces.• Educational programs that are developed, implemented, and evaluated using principles of adult learning.	
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