

National Patient Safety Goals®

Effective January 2025 for the Assisted Living Community Program

Goal 1

Improve the accuracy of resident identification.

NPSG.01.01.01

Use at least two 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 resident, one identifier can be facial recognition.

--Rationale for NPSG.01.01.01--

Providing care or services to the wrong resident can occur in virtually all stages of diagnosis and treatment. The intent of this goal is two-fold: first, to reliably identify the resident as the person for whom the service or treatment is intended; second, to match the service or treatment to that 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 resident identifiers when administering medications; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The 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 resident.

Goal 3

Improve the safety of using medications.

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 resident should be using (and is actually using) to the new medications that are ordered for the 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 resident was prescribed and what medications the resident is actually taking. It can be difficult to obtain a complete list from every resident in an initial encounter, and accuracy is dependent on the 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.

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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 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) 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 residents. It is often important for physicians or other licensed practitioners to know what medications the 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 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 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

- EP 1 Obtain information (for example, name, dose, route, frequency, duration, purpose) on the medications the resident is currently taking when they move into or is 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 resident's medication information when the resident enters the organization. This information is updated when the 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 resident. A good faith effort to obtain this information from a 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 resident brought to the organization with the medications ordered for the resident by the physician or other licensed practitioner 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.

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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 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 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

- 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 resident harm resulting from falls.

NPSG.09.02.01

Reduce the risk of falls.

--Rationale for NPSG.09.02.01--

Assisted living residents are vulnerable to the effects of muscle weakness, chronic health conditions, polypharmacy, and sensory deficits. This can lead to a loss of balance leading to a fall that potentially causes injury. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate the 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 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.

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Element(s) of performance for NPSG.09.02.01

- EP 1 Assess the resident's risk for falls.
- EP 2 Implement interventions to reduce falls based on the resident's assessed risk.
- EP 3 Educate staff on the fall reduction program in time frames determined by the organization.
- EP 4 Educate the 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 injury.
