

National Patient Safety Goals®

Effective January 2025 for the Home Care Program

Goal 1

Improve the accuracy of patient identification.

NPSG.01.01.01

Use at least two patient identifiers when providing care, treatment, or services.

Note: In the home care setting, patient identification is less prone to error than in other settings. 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 licensed practitioner "knows" the patient, one of the identifiers can be facial recognition. In the home, the correct address is also confirmed. The patient's confirmed address is an acceptable identifier when used in conjunction with another individual-specific identifier.

--Rationale for NPSG.01.01.01--

Wrong-patient errors 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.

Element(s) of performance for NPSG.01.01.01

- EP 1 Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. (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.

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 patient should be using (and is actually using) to the new medications that are ordered for the patient 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 was prescribed and what medications the patient is actually taking. It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient'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 patient 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 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. It is often important for physicians and other licensed practitioners to know what medications the patient is taking when planning care, treatment, or services, even in situations where medications are not used.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

--Rationale for NPSG.03.06.01--

There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient 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 and 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 and/or update information on the medications the patient is currently taking. 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 medication information during the first contact. The information is updated when the patient'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 a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

Ⓧ Documentation is required.

EP 2 Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in different settings and patient circumstances.

EP 3 Compare the medication information the patient is currently taking with the medications ordered for the patient 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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EP 4 Provide the patient (or family as needed) with written information on the medications the patient should be taking when they leave the organization's care (for example, name, dose, route, frequency, purpose).

ⓓ Documentation is required.

EP 5 Explain the importance of managing medication information to the patient.

Note: Examples include instructing the patient to give a list to their primary care physician or other licensed practitioner; 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 patient education on medications, 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, or services in a health care organization. Consequently, health care–associated infections (HAIs) are a patient 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, 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.

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Goal 9

Reduce the risk of patient 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, 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 evaluate the patient'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 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 risk for falls.
- EP 2 Implement interventions to reduce falls based on the patient's assessed risk.
- EP 3 Educate staff on the fall reduction program in time frames determined by the organization.
- EP 4 Educate the patient 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 15

The organization identifies safety risks inherent in its patient population.

NPSG.15.02.01

Identify risks associated with home oxygen therapy such as home fires.

--Rationale for NPSG.15.02.01--

A critical aspect of safe patient care at home relates to the use of oxygen. Oxygen administration presents a high risk for fire due to the acceleration of flame that oxygen causes in the presence of flammable substances (such as upholstery and clothing) and open flames (such as candles, gas appliances, and smoking materials). Smoking is a major reason for burn incidents involving home medical oxygen therapy. Oxygen cylinders that are not safely stored create risks for fire and explosion; standards addressing storage of cylinders are included in the "Environment of Care" (EC) chapter.

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This NPSG addresses the importance of a home oxygen assessment that identifies potential safety risks in the environment. Patients and families need to understand and modify behaviors that could lead to a serious safety event. For that reason, home care agencies that interact with their patients have a responsibility to reduce risk by assessing the environment and educating the patient and family. Issues to consider in both the home risk assessment and in patient and family education include whether or not the patient lives alone, the patient's cognitive ability, and whether individuals smoke in the home.

An oxygen safety risk assessment should be conducted before starting oxygen therapy in the home and when home care services are initiated. However, when more than one organization provides services in the home, it is the responsibility of each organization to assess potential fire risks when its staff enters the home.

Element(s) of performance for NPSG.15.02.01

EP 1 Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following:

- Whether there are smoking materials in the home
- Whether or not the home has functioning smoke detectors

Note: Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required.

- Whether there are other fire safety risks in the home, such as the potential for open flames

Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5)

Ⓧ Documentation is required.

EP 2 Reevaluate potential fire risks at intervals established by the organization. Evidence of unsafe practices leading to potential risk is used to establish these intervals. Document the reevaluation of potential fire risks.

Ⓧ Documentation is required.

EP 3 Inform and educate the patient, family, and/or caregiver about the following:

- The findings of the safety risk assessment
- The causes of fire
- Fire risks for neighboring residences and buildings
- Precautions that can prevent fire-related injuries
- Recommendations to address the specific identified risk(s)

Document the provision of information and education. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

Ⓧ Documentation is required.

EP 4 Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.

Ⓧ Documentation is required.

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- EP 5 Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the physician or other licensed practitioner ordering the oxygen. Document the implementation of strategies to address compliance.

Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.

Ⓧ Documentation is required.
