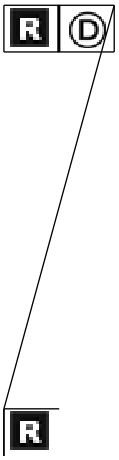
National Patient Safety Goals®
Effective January 2024 for the Nursing Care Center Program

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



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.

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.

National Patient Safety Goals® Effective January 2024 for the Nursing Care Center Program

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 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

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. R
2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 1) R
3. Improve compliance with hand hygiene guidelines based on established goals. R

Goal 9

Reduce the risk of patient and resident 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, 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

1. Assess the patient's or resident's risk for falls. R

National Patient Safety Goals®
Effective January 2024 for the Nursing Care Center Program

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 heath 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

1.	Create a written plan for risk identification, prevention, and treatment of pressure injuries based on clinical practice guidelines and evidence-based practices.	R D
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.	R
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.	R
4.	Reassess pressure injury risk or wound condition at intervals defined by the organization or as ordered by a physician or other licensed practitioner.	R
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	R
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.	R
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.	R D
8.	Physicians and other licensed practitioners receive ongoing training on pressure injury risk identification, prevention protocols, staging, and documentation.	R D
9.	Patients, residents, and families receive education about pressure injury prevention.	R