

National Patient Safety Goals Effective January 1, 2012

Hospital Accreditation Program



NPSG.01.01.01

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

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.




Elements of Performance for NPSG.01.01.01

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| M 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. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1) |  C |
| 2. | Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1) |  A |
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NPSG.01.03.01

Eliminate transfusion errors related to patient misidentification.

Elements of Performance for NPSG.01.03.01

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| 1. | Before initiating a blood or blood component transfusion:
- Match the blood or blood component to the order.
- Match the patient to the blood or blood component.
- Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding.
(See also NPSG.01.01.01, EPs 1 and 2) |  A |
| 2. | When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient. |  A |
| 3. | When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process, as determined by the hospital. |  A |
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Hospital National Patient Safety Goals

NPSG.02.03.01

Report critical results of tests and diagnostic procedures on a timely basis.

Rationale for NPSG.02.03.01

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

Elements of Performance for NPSG.02.03.01

1. **D** Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following: A
 - The definition of critical results of tests and diagnostic procedures
 - By whom and to whom critical results of tests and diagnostic procedures are reported
 - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures
 2. Implement the procedures for managing the critical results of tests and diagnostic procedures. A
 3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures. A
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NPSG.03.04.01

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.


Note: Medication containers include syringes, medicine cups, and basins.



Rationale for NPSG.03.04.01

Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of safe medication management, yet it is routine in many organizations.

The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09.






Elements of Performance for NPSG.03.04.01

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.  A

Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Refer to NPSG.03.04.01, EP 5, for information on timing of labeling.
 2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.  A
 3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:  A
 - Medication name
 - Strength
 - Quantity
 - Diluent and volume (if not apparent from the container)
 - Expiration date when not used within 24 hours
 - Expiration time when expiration occurs in less than 24 hours

Note: The date and time are not necessary for short procedures, as defined by the hospital.
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| M | <p>4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.</p> |  | C |
| | <p>5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.
 Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.</p> |  | A |
| | <p>6. Immediately discard any medication or solution found unlabeled.</p> |  | A |
| | <p>7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
 Note: This does not apply to multiuse vials that are handled according to infection control practices.</p> |  | A |
| M | <p>8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.</p> |  | C |

NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.




Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

Rationale for NPSG.03.05.01

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG.03.05.01

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| | <p>1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
 Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.</p> |  | A |
| M | <p>2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.</p> |  | C |
| | <p>3. Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.
 Note: The patient's baseline coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors.</p> |  | A |

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| | 4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin. | 3 | A |
| | 5. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing. | 3 | A |
| | 6. D A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants. | 3 | A |
| M | 7. Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following:
- The importance of follow-up monitoring
- Compliance
- Drug-food interactions
- The potential for adverse drug reactions and interactions | 3 | C |
| | 8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization. | | A |

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 (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

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| M | 1. D Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
Note 1: 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 2: 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. | 3 | C |
| | 2. Define the types of medication information to be collected in non–24-hour settings and different patient circumstances.
Note 1: Examples of non–24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.
Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose. | 3 | A |
| M | 3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.
Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. (See also HR.01.06.01, EP 1) | 3 | C |

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- M** 4. **D** Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).  C
Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.
- M** 5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.  C
Note: Examples include instructing the patient 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 patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)
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
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 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) 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, and monitors compliance and provides feedback.

Elements of Performance for NPSG.07.01.01

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

Hospital National Patient Safety Goals

NPSG.07.03.01

Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.



Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

Rationale for NPSG.07.03.01


Patients continue to acquire health care–associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care–associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient's environment are essential strategies for preventing the spread of health care–associated infections. Hand hygiene is addressed in NPSG.07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC.02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC.02.02.01.

Elements of Performance for NPSG.07.03.01

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| 1. | Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1-5) | A |
| M 2. | Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.
Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the hospital. | C |
| M 3. | Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection prevention strategies. | C |
| 4. | Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.
Note: Surveillance may be targeted rather than hospital-wide. | A |
| 5. | Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
- Multidrug-resistant organism infection rates using evidence-based metrics
- Compliance with evidence-based guidelines or best practices
- Evaluation of the education program provided to staff and licensed independent practitioners
Note: Surveillance may be targeted rather than hospital-wide. | A |
| 6. | Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. | A |
| 7. | Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). |  C |
| 8. | When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.
Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods. |  A |

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











9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.  A
- Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.
- Note 2: Each hospital may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.

NPSG.07.04.01




Implement evidence-based practices to prevent central line–associated bloodstream infections.

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

Elements of Performance for NPSG.07.04.01

-  1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual's job responsibilities. C
-  2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention. C
-  3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).  C
4. Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital-wide, not targeted. A
5. Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. A
-  6.  Use a catheter checklist and a standardized protocol for central venous catheter insertion.  C
-  7. Perform hand hygiene prior to catheter insertion or manipulation.  C
-  8. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.  C
-  9. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.  C
-  10. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.  C


Hospital National Patient Safety Goals

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| M | 11. | Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations. * |  | C |
| Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows. | | | | |
| M | 12. | D Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. |  | C |
| M | 13. | Evaluate all central venous catheters routinely and remove nonessential catheters. |  | C |



NPSG.07.05.01

Implement evidence-based practices for preventing surgical site infections.

Elements of Performance for NPSG.07.05.01

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| M | 1. | Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual's job responsibilities. | | C |
| M | 2. | Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention. | | C |
| M | 3. | Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). |  | C |
| | 4. | As part of the effort to reduce surgical site infections:
- Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
- Select surgical site infection measures using best practices or evidence-based guidelines.
- Monitor compliance with best practices or evidence-based guidelines.
- Evaluate the effectiveness of prevention efforts.
Note: Surveillance may be targeted to certain procedures based on the hospital's risk assessment. | | A |
| | 5. | Measure surgical site infection rates for the first 30 days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices. The hospital's measurement strategies follow evidence-based guidelines.
Note: Surveillance may be targeted to certain procedures based on the hospital's risk assessment. | | A |
| | 6. | Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders. | | A |

Hospital National Patient Safety Goals

- M** 7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations. *  C
Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.
8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations. *  C
Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.




NPSG.07.06.01

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI). *

Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children.

Footnote *: Evidence-based guidelines for CAUTI are located at: Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals at, <http://www.shea-online.org/about/compendium.cfm> and Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009 at http://www.cdc.gov/hicpac/cauti/001_cauti.html

Elements of Performance for NPSG.07.06.01

1. During 2012, plan for the full implementation of this NPSG by January 1, 2013.  A
Note: Planning may include a number of different activities, such as assigning responsibility for implementation activities, creating time lines, identifying resources, and pilot testing.
- M** 2. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:  C
- Limiting use and duration to situations necessary for patient care
- Using aseptic techniques for site preparation, equipment, and supplies
- M** 3. Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:  C
- Securing catheters for unobstructed urine flow and drainage
- Maintaining the sterility of the urine collection system
- Replacing the urine collection system when required
- Collecting urine samples

Hospital National Patient Safety Goals

4. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following: A
- Selecting measures using evidence-based guidelines or best practices
 - Monitoring compliance with evidence-based guidelines or best practices
 - Evaluating the effectiveness of prevention efforts
- Note: Surveillance may be targeted to areas with a high volume of patients using in-dwelling catheters. High-volume areas are identified through the hospital's risk assessment as required in IC.01.03.01, EP 2.
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NPSG.15.01.01




Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Rationale for NPSG.15.01.01

Suicide of a patient 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

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

Hospital National Patient Safety Goals

UP.01.01.01

Conduct a preprocedure verification process.

Rationale for UP.01.01.01

Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:




- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:

- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.



Elements of Performance for UP.01.01.01

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.  A
Note: The patient is involved in the verification process when possible.
2.  Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:  A
 - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
 - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
 - Any required blood products, implants, devices, and/or special equipment for the procedureNote: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.
3. Match the items that are to be available in the procedure area to the patient. A





UP.01.02.01

Mark the procedure site.

Elements of Performance for UP.01.02.01

-  1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.  C
Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

Hospital National Patient Safety Goals

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| <p>Ⓜ</p> | <p>2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.</p> | <p> C</p> |
| <p>Ⓜ</p> | <p>3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:</p> <ul style="list-style-type: none"> - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed. <p>Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.</p> | <p> C</p> |
| <p>4.</p> | <p>The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.</p> <p>Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.</p> | <p> A</p> |
| <p>5. ⓓ</p> | <p>A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).</p> <p>Note: Examples of other situations that involve alternative processes include:</p> <ul style="list-style-type: none"> - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice - Teeth - Premature infants, for whom the mark may cause a permanent tattoo | <p> A</p> |

UP.01.03.01


A time-out is performed before the procedure.

Rationale for UP.01.03.01




The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

Elements of Performance for UP.01.03.01

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| <p>1.</p> | <p>Conduct a time-out immediately before starting the invasive procedure or making the incision.</p> | <p> A</p> |
| <p>2.</p> | <p>The time-out has the following characteristics:</p> <ul style="list-style-type: none"> - It is standardized, as defined by the hospital. - It is initiated by a designated member of the team. - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning. | <p>A</p> |

Hospital National Patient Safety Goals

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| 3. | When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated. |  | A |
| 4. | During the time-out, the team members agree, at a minimum, on the following:
- Correct patient identity
- The correct site
- The procedure to be done |  | A |
| M | 5. Document the completion of the time-out.
Note: The hospital determines the amount and type of documentation. |  | C |