
# Hospital Accreditation Program

## 2009 Chapter: National Patient Safety Goals

## Goal 1

Improve the accuracy of [patient] identification.

## 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.

**Elements of Performance for NPSG.01.01.01**

1 Prior to any specimen collection, medication administration, transfusion, or treatment, the hospital actively involves the patient, and as needed the family, in the identification and matching process. When active patient involvement is not possible or the patient's reliability is in question, the hospital will designate the caregiver responsible for identity verification.
Note: The involvement of a single caregiver is acceptable as long as the other components of patient identification are satisfied.

2 Two patient identifiers are used when administering medications, blood, or blood components.

3 Two patient identifiers are used when collecting blood samples and other specimens for clinical testing.

4 Two patient identifiers are used when providing other treatments or procedures.

5 The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11)

6 Containers used for blood and other specimens are labeled in the presence of the patient.

## 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, the patient is objectively matched to the blood or blood component during a two-person bedside or chair-side verification process. At least two unique identifiers are used in the process, and it is conducted after the blood or blood component that matches the order has been issued or dispensed.<br>Note: If two individuals are not available, an automated identification technology (for example, bar coding) may be used in place of one of the individuals. |
| 2 | When using a two-person bedside or chair-side verification process, one individual conducting the identification verification must be the qualified transfusionist who will administer the blood or blood component to the patient. |
| 3 | When using a two-person bedside or chair-side verification process, the second individual conducting the identification verification must be qualified to participate in the process. |

## Goal 2

Improve the effectiveness of communication among caregivers.

## NPSG.02.01.01

For verbal or telephone orders or for telephone reporting of critical test results, the individual giving the order or test result verifies the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.

**Rationale for NPSG.02.01.01**

Ineffective communication is the most frequently cited root cause for sentinel events. Effective communication that is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved [patient] safety.

**Elements of Performance for NPSG.02.01.01**

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| 1 | The individual receiving the information writes down the complete order or test result or enters it into a computer. |
| 2 | The individual receiving the information reads back the complete order or test result. |
| 3 | The individual who gave the order or test result confirms the information that was read back. |

## NPSG.02.02.01

There is a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the [organization].

**Elements of Performance for NPSG.02.02.01**

1 The hospital develops a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the hospital.

2 The current list of abbreviations, acronyms, symbols, and dose designations not to be used includes the following:
- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

Note: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

3 The hospital implements the “do not use” list of abbreviations, acronyms, symbols, and dose designations and applies it to all orders and all medication-related documentation that is handwritten or entered as free text into a computer.

4 The hospital does not include any abbreviations, acronyms, symbols, and dose designations identified as not to be used on preprinted forms.

## NPSG.02.03.01

The [organization] measures, assesses, and, if needed, takes action to improve the timeliness of reporting, and the timeliness of receipt of critical tests and critical results and values by the responsible licensed caregiver.

**Elements of Performance for NPSG.02.03.01**

1 The hospital defines critical tests and critical results and values.

2 The hospital defines the acceptable length of time between the ordering of critical tests and reporting the results of these tests, whether normal or abnormal.

3 The hospital defines the acceptable length of time for reporting the results of routine tests with critical abnormal values or findings.

4 The hospital defines the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed caregiver.

5 The hospital collects data on the timeliness of reporting critical test results and critical results and values from routine tests.

6 The hospital assesses the data on the timeliness of reporting critical test results and critical results and values from routine tests and determines whether a need for improvement exists.

7 The hospital takes appropriate action to improve the timeliness of reporting critical test results and critical results and values from routine tests and measures the effectiveness of those actions.

## NPSG.02.05.01

The [organization] implements a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.

**Rationale for NPSG.02.05.01**

Health care has numerous types of [patient] hand-offs, including, but not limited to, nursing shift changes; physician transfer of complete responsibility for a [patient]; physician transfer of on-call responsibility; acceptance of temporary responsibility for staff leaving the unit for a 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; and critical laboratory and radiology results sent to physician offices. The primary objective of a hand-off is to provide accurate information about a [patient'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.

**Elements of Performance for NPSG.02.05.01**

1 The hospital's process for effective hand-off communication includes the following: Interactive communications that allows for the opportunity for questioning between the giver and receiver of patient information.

2 The hospital's process for effective hand-off communication includes the following: Up-to-date information regarding the patient's condition, care, treatment, medications, services, and any recent or anticipated changes. (See also NPSG.08.01.01, EP 4)

3 The hospital's process for effective hand-off communication includes the following: A method to verify the received information, including repeat-back or read-back techniques.

4 The hospital's process for effective hand-off communication includes the following: An opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous care, treatment, and services.

5 Interruptions during hand-offs are limited to minimize the possibility that information fails to be conveyed or is forgotten.

## Goal 3

Improve the safety of using medications.

## NPSG.03.03.01

The [organization] identifies and, at a minimum, annually reviews a list of look-alike/sound-alike medications used by the [organization] and takes action to prevent errors involving the interchange of these medications.

**Elements of Performance for NPSG.03.03.01**

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| 1 | The hospital identifies a list of look-alike/sound-alike medications used by the hospital. The list includes a minimum of 10 look-alike/sound-alike medication combinations selected from the tables of look-alike/sound-alike medications posted on The Joint Commission Web site at http://www.jointcommission.org. |
| 2 | The hospital reviews the list of look-alike/sound-alike medications at least annually. |
| 3 | The hospital takes action to prevent errors involving the interchange of the medications on the list of look-alike/sound-alike medication list. |

## NPSG.03.04.01

Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

**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 medication management safety yet has been routine in many organizations.

The labeling of all medications, medication containers, and solutions is a risk reduction activity consistent with safe medication practices. This practice addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings.

**Elements of Performance for NPSG.03.04.01**

1 Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.

2 Labeling occurs when any medication or solution is transferred from the original packaging to another container.

3 Medication or solution labels include the medication 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.

4 All medication or solution labels are verified both verbally and visually by two qualified individuals whenever the person preparing the medication or solution is not the person who will be administering it.

5 No more than one medication or solution is labeled at one time.

6 Any medications or solutions found unlabeled are immediately discarded.

7 All original containers from medications or solutions remain available for reference in the perioperative or procedural area until the conclusion of the procedure.

8 All labeled containers on the sterile field are discarded at the conclusion of the procedure.

9 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.

## NPSG.03.05.01

Reduce the likelihood of [patient] harm associated with the use of anticoagulation therapy.
Note: This requirement applies only to [organization]s that provide anticoagulation 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 where 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 poses risks to patients and often leads to adverse drug events due to complex dosing, requisite follow-up monitoring, and inconsistent [patient] compliance. The use of standardized practices for anticoagulation therapy that include [patient] involvement can reduce the risk of adverse drug events associated with the use of heparin (unfractionated), low molecular weight heparin (LMWH), and warfarin.

**Elements of Performance for NPSG.03.05.01**

1. The hospital implements a defined anticoagulation management program to individualize the care provided to each patient receiving anticoagulant therapy.
2. To reduce compounding and labeling errors, the hospital uses only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags when these types of products are available.
   Note: For pediatric patients, pre-loaded syringe products should only be used if specifically designed for children.
3. The hospital uses approved protocols for the initiation and maintenance of anticoagulation therapy appropriate to the medication used, to the condition being treated, and to the potential for medication interactions.
4. For patients starting on warfarin, a baseline International Normalized Ratio (INR) is available, and for all patients receiving warfarin therapy, a current INR is available and is used to monitor and adjust therapy.
5. When dietary services are provided by the hospital, the service is notified of all patients receiving warfarin and responds according to its established food/medication interaction program.
6. When heparin is administered intravenously and continuously, the hospital uses programmable infusion pumps in order to provide consistent and accurate dosing.
7. The hospital has a written policy that addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.
8. The hospital provides education regarding anticoagulation therapy to prescribers, staff, patients, and families.
   Note: Patient/family education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions.
9. The hospital evaluates its anticoagulation safety practices, takes appropriate action to improve its practices, and measures the effectiveness of those actions on a regular basis.

# Goal 7

Reduce the risk of health care associated infections.

## NPSG.07.01.01

Comply with current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

**Rationale for NPSG.07.01.01**

Compliance with the WHO or CDC hand hygiene guidelines will reduce the transmission by staff to [patient]s of infectious agents, thereby decreasing the incidence of health care associated infections.

**Elements of Performance for NPSG.07.01.01**

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| 1 | The hospital complies with current World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.<br>Note: Hospitals are required to comply with 1A, 1B, and 1C of the WHO or CDC guidelines. |

## NPSG.07.02.01

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care associated infection.

**Rationale for NPSG.07.02.01**

A significant percentage of [patient]s who unexpectedly die or suffer major permanent loss of function have health care 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 these questions: Why did the [patient] acquire an infection? Why did the [patient] die or suffer permanent loss of function?

**Elements of Performance for NPSG.07.02.01**

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|---|---|
| 1 | The hospital manages all identified cases of unanticipated death or major permanent loss of function associated with a health care associated infection as sentinel events (that is, the hospital conducts a root cause analysis). |
| 2 | The root cause analysis addresses the management of the patient before and after the identification of infection. |

## NPSG.07.03.01

Implement evidence-based practices to prevent health care associated infections due to multiple drug-resistant organisms in acute care hospitals.
Note 1: 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 multiple drug-resistant gram negative bacteria.
Note 2: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing (milestones) at three, six, and nine months in 2009, with the expectation of full implementation by January 1, 2010.

**Rationale for NPSG.07.03.01**

[Patient]s continue to acquire health care associated infections at an alarming rate. Risks and [patient] populations, however, differ between [organization]s. Therefore, prevention and control strategies must be tailored to the specific needs of each [organization] 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 multiple drug 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 [patient]s with epidemiologically significant multi-drug 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**

1 As of April 1, 2009, the hospital's leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG.07.03.01.

2 As of July 1, 2009, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG.07.03.01 by January 1, 2010.

3 As of October 1, 2009, pilot testing in at least one clinical unit is under way, for the requirements in NPSG.07.03.01.

4 As of January 1, 2010, the elements of performance in NPSG.07.03.01 are fully implemented across the hospital.

5 As of January 1, 2010: Conduct periodic risk assessments for multi-drug resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1-5)

6 As of January 1, 2010: Based on the results of the risk assessment, the hospital educates staff and licensed independent practitioners about health care associated infections, multi-drug 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. (See also HR.01.05.03, EP 4)

7 As of January 1, 2010: The hospital educates patients, and their families as needed, who are infected or colonized with a multi-drug resistant organism about health care associated infection strategies.

8 As of January 1, 2010: The hospital implements a surveillance program for multi-drug resistant organisms based on the risk assessment.

9 As of January 1, 2010: The hospital measures and monitors multi-drug resistant organism prevention processes and outcomes including the following:
- Multi-drug 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.

10 As of January 1, 2010: The hospital provides multi-drug resistant organism surveillance data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

11 As of January 1, 2010: The hospital implements policies and practices aimed at reducing the risk of transmitting multi-drug resistant organisms that 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).

12 As of January 1, 2010: When indicated by the risk assessment, the hospital implements a laboratory-based alert system that identifies new patients with multi-drug resistant organisms. The alert system may be either manual or electronic or a combination of both of these methods.
Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.

13 As of January 1, 2010: When indicated by the risk assessment, the hospital implements an alert system that identifies readmitted or transferred multi-drug resistant organism-positive patients.
Note: 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.

## NPSG.07.04.01

Implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections.
Note 1: This requirement covers short and long term central venous catheters and peripherally inserted central catheter (PICC) lines.
Note 2: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing ("milestones") at three, six, and nine months in 2009, with the expectation of full implementation by January 1, 2010.

**Elements of Performance for NPSG.07.04.01**

1 As of April 1, 2009, the hospital's leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG.07.04.01.

2 As of July 1, 2009, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG.07.04.01 by January 1, 2010.

3 As of October 1, 2009, pilot testing in at least one clinical unit is under way, for the requirements in NPSG.07.04.01.

4 As of January 1, 2010, the elements of performance in NPSG.07.04.01 are fully implemented across the hospital.

5 As of January 1, 2010: The hospital educates health care workers who are involved in these procedures about health care associated infections, 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.

6 As of January 1, 2010: Prior to insertion of a central venous catheter, the hospital educates patients, and their families as needed, about central line-associated bloodstream infection prevention.

7 As of January 1, 2010: The hospital implements policies and practices aimed at reducing the risk of central line-associated bloodstream infections that 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).

8 As of January 1, 2010: The hospital conducts periodic risk assessments for surgical site infections, measures central line-associated bloodstream infection rates, monitors compliance with best practices or evidence-based guidelines, and evaluates the effectiveness of prevention efforts.

9 As of January 1, 2010: The hospital provides central line-associated bloodstream infections rate data and prevention outcome measures to key stakeholders including leaders, licensed independent practitioners, nursing staff, and other clinicians.

10 As of January 1, 2010: Use a catheter checklist and a standardized protocol for central venous catheter insertion.

11 As of January 1, 2010: Perform hand hygiene prior to catheter insertion or manipulation.

12 As of January 1, 2010: For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.

13 As of January 1, 2010: Use a standardized supply cart or kit that is all inclusive for the insertion of central venous catheters.

14 As of January 1, 2010: Use a standardized protocol for maximum sterile barrier precautions during central venous catheter insertion.

15 As of January 1, 2010: Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients over two months of age, unless contraindicated.

16 As of January 1, 2010: Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.

17 As of January 1, 2010: Evaluate all central venous catheters routinely and remove nonessential catheters.

## NPSG.07.05.01

Implement best practices for preventing surgical site infections.
Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing ("milestones") at three, six, and nine months in 2009, with the expectation of full implementation by January 1, 2010.

**Elements of Performance for NPSG.07.05.01**

1 As of April 1, 2009, the hospital's leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG.07.05.01.

2 As of July 1, 2009, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG.07.05.01 by January 1, 2010.

3 As of October 1, 2009, pilot testing in at least one clinical unit is under way, for the requirements in NPSG.07.05.01.

4 As of January 1, 2010, the elements of performance in NPSG.07.05.01 are fully implemented across the hospital.

5 As of January 1, 2010: The hospital educates health care workers involved in surgical procedures about health care associated infections, 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.

6 As of January 1, 2010: Prior to all surgical procedures, the hospital educates patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.

7 As of January 1, 2010: The hospital implements policies and practices aimed at reducing the risk of surgical site infections that 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). (See also UP.01.03.01, EP 5)

8 As of January 1, 2010: The hospital conducts periodic risk assessments for surgical site infections, selects surgical site infection measures using best practices or evidence-based guidelines, monitors compliance with best practices or evidence-based guidelines, and evaluates the effectiveness of prevention efforts.

9 As of January 1, 2010: Measurement strategies follow evidence-based guidelines and surgical site infection rates are measured for the first 30 days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices.

10 As of January 1, 2010: The hospital provides surgical site infection rate data and prevention outcome measures to key stakeholders including leaders, licensed independent practitioners, nursing staff, and other clinicians.

11 As of January 1, 2010: Antimicrobial agents for prophylaxis used for a particular procedure or disease are administered according to evidence-based standards and guidelines for best practices.
- Administer intravenous antimicrobial prophylaxis within one hour before incision (two hours are allowed for the administration of vancomycin and fluoroquinolones).
- Discontinue the prophylactic antimicrobial agent within 24 hours after surgery (within 48 hours is allowable for cardiothoracic procedures).
Footnote: See Joint Commission core measures at www.jointcommission.org/PerformanceMeasurement.

12 As of January 1, 2010: When hair removal is necessary, the hospital uses clippers or depilatories.
Note: Shaving is an inappropriate hair removal method.

## Goal 8

Accurately and completely reconcile medications across the continuum of care.

## NPSG.08.01.01

A process exists for comparing the [patient]'s current medications with those ordered for the [patient] while under the care of the [organization].

**Rationale for NPSG.08.01.01**

[Patient]s are at high risk for harm from adverse drug events when communication about medications is not clear. The chance for communication errors increases whenever individuals involved in a [patient]'s care change. Communicating about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.

**Elements of Performance for NPSG.08.01.01**

1 At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient, and family as needed, are involved in creating this list.

2 The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.

3 Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.

4 When the patient's care is transferred within the hospital (for example, from the ICU to a floor), the current provider(s) inform the receiving provider(s) about the up-to-date reconciled medication list and document the communication. (See also NPSG.02.05.01, EP 2)
Note: Updating the status of a patient's medications is also an important component of all patient care hand-offs.

## NPSG.08.02.01

When a [patient] is referred to or transferred from one [organization] to another, the complete and reconciled list of medications is communicated to the next provider of service and the communication is documented. Alternatively, when a [patient] leaves the [organization]'s care directly to his or her home, the complete and reconciled list of medications is provided to the [patient]'s known primary care provider, or the original referring provider, or a known next provider of service.
Note: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the [patient], and family as needed, the list of reconciled medications is sufficient.

**Rationale for NPSG.08.02.01**

The accurate communication of a [patient]'s reconciled medication list to the next provider of service reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the [patient]'s medications and to safely order/prescribe other medications that may be needed. This communication is especially important at transitions in care when a [patient] is referred or transferred from one organization to another.

**Elements of Performance for NPSG.08.02.01**

1 The patient's most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented.

2 At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications.

## NPSG.08.03.01

When a [patient] leaves the [organization]'s care, a complete and reconciled list of the [patient]'s medications is provided directly to the [patient], and the [patient]'s family as needed, and the list is explained to the [patient] and/or family.

**Rationale for NPSG.08.03.01**

The accurate communication of the [patient]'s medication list to the [patient] and to the [patient]'s family, if needed, reduces the risk of transition-related adverse drug events. A thorough knowledge of the [patient]'s medications is essential for the [patient]'s primary care provider or next provider of service to manage the subsequent stages of care for the [patient].

**Elements of Performance for NPSG.08.03.01**

1 When the patient leaves the hospital's care, the current list of reconciled medications is provided and explained to the patient, and their family as needed. This interaction is documented.
Note: Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

## NPSG.08.04.01

In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.
Note: This requirement does not apply to [organization]s that do not administer medications. It may be important for health care organizations to know what types of medications their [patient]s are taking because these medications could affect the care, treatment, and services provided.

**Rationale for NPSG.08.04.01**

A number of [patient] care settings exist in which medications are not used, are used minimally, or prescribed for only a short duration. This includes areas such as the emergency department, urgent and emergent care, convenient care, office-based surgery, outpatient radiology, ambulatory care, and behavioral health care. In these settings, obtaining a list of the [patient]'s original, known, and current medications that he or she is taking at home is still important; however, obtaining information on the dose, route, and frequency of use is not required.

**Elements of Performance for NPSG.08.04.01**

1 The hospital obtains and documents an accurate list of the patient's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, intravenous contrast media, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.

2 When only short-term medications (for example, a pre-procedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the patient's current medication list, the patient, and their family as needed, is provided with a list containing the short term medication additions that the patient will continue after leaving the hospital.
Note: This list of new short term medications is not considered to be part of the original, known and current medication list. When patients leave these settings, a list of the original, known, and current medications does not need to be provided, unless the patient is assessed to be confused or unable to comprehend adequately. In this case, the patient's family is provided both medication lists and the circumstances are documented.

3 In these settings, a complete, documented medication reconciliation process is used when: Any new long term (chronic) medications are prescribed.

4 In these settings, a complete, documented medication reconciliation process is used when: There is a prescription change for any of the patient's current, known long-term medications.

5 In these settings, a complete, documented medication reconciliation process is used when: The patient is required to be subsequently admitted to an organization from these settings for ongoing care.

6 When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient, and their family as needed, and to the patient's known primary care provider or original referring provider or a known next provider of service.

## Goal 9

Reduce the risk of [patient] harm resulting from falls.

## NPSG.09.02.01

The [organization] implements a fall reduction program that includes an evaluation of the effectiveness of the program.

**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.

**Elements of Performance for NPSG.09.02.01**

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|---|---|
| 1 | The hospital establishes a fall reduction program. |
| 2 | The fall reduction program includes an evaluation appropriate to the patient population, settings, and services provided. |
| 3 | The fall reduction program includes interventions to reduce the patient's fall risk factors. |
| 4 | Staff receive education and training for the fall reduction program. |
| 5 | The hospital educates the patient, and their family as needed, on the fall reduction program and any individualized fall reduction strategies. |
| 6 | The hospital evaluates the fall reduction program to determine the effectiveness of the program.<br>Note: Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used. |

## Goal 13

Encourage [patient]s' active involvement in their own care as a [patient] safety strategy.

## NPSG.13.01.01

Identify the ways in which the [patient] and his or her family can report concerns about safety and encourage them to do so.

**Rationale for NPSG.13.01.01**

Communication with the [patient] and family about all aspects of care, treatment, and services is an important characteristic of a culture of safety. When the [patient] knows what to expect, he or she is more aware of possible errors and choices. The [patient] can also be an important source of information about potential adverse events and hazardous conditions.

**Elements of Performance for NPSG.13.01.01**

1 The patient and family are educated on available reporting methods for concerns related to care, treatment, services and patient safety issues.

2 The hospital provides the patient with information regarding infection control measures for hand hygiene practices, respiratory hygiene practices and contact precautions according to the patient's condition. The information is discussed with the patient and his or her family members on the day the patient enters the hospital or as soon as possible (for example, within 24–48 hours). The patient's understanding of this information is evaluated and documented. (See also PC.02.03.01, EP 25)
Note: The information provided to the patient may be in any form of media.

3 For surgical patients, the hospital describes the measures that will be taken to prevent adverse events in surgery. Examples include, but are not limited to, patient identification practices, prevention of surgical infections, and marking of the procedure sites. The patient's understanding is evaluated and documented. (See also PC.02.03.01, EP 25)
Note: The information provided to the patient may be in any form of media.

4 The hospital encourages patients and their families to report concerns about safety.

## Goal 15

The organization identifies safety risks inherent in its [patient] population.

## NPSG.15.01.01

The [organization] identifies [patient]s at risk for suicide.
Note: This requirement only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

**Rationale for NPSG.15.01.01**

Suicide of a care recipient 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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|---|---|
| 1 | The risk assessment includes identification of specific patient factors and environmental features that may increase or decrease the risk for suicide. |
| 2 | The hospital addresses the patient's immediate safety needs and most appropriate setting for treatment. |
| 3 | The hospital provides information such as a crisis hotline to individuals at risk for suicide and their family members. |

## Goal 16

Improve recognition and response to changes in a patient's condition.

## NPSG.16.01.01

The [organization] selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the [patient]'s condition appears to be worsening.

**Rationale for NPSG.16.01.01**

A significant number of critical inpatient events are preceded by warning signs prior to the event. A majority of [patient]s who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a [patient]'s condition by a specially trained individual(s) may reduce cardiopulmonary arrests and [patient] mortality.

**Elements of Performance for NPSG.16.01.01**

1 The hospital selects an early recognition and response method most suitable for its needs and resources.

2 The hospital develops criteria for calling additional assistance to respond to a change in the patient's condition or a perception of change by the staff, the patient, and/or family.

3 Based on the hospital's criteria, staff seek additional assistance when they have concerns about a patient's condition.

4 The hospital encourages the patient and family to seek assistance when the patient's condition worsens.

5 Formal education for urgent response policies and practices is conducted with the staff and licensed independent practitioners who may request assistance and those who may respond to those requests.

6 The hospital measures cardiopulmonary arrest, respiratory arrest, and mortality rates before and after implementation of an early intervention plan.

7 The hospital evaluates its early intervention program and any underlying organizational system issues, takes appropriate action to improve its intervention system, and measures the effectiveness of those actions on a regular basis.
Note: Hospitals are not required to create "rapid response teams" or "medical emergency teams" in order to meet this goal. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.

## Universal Protocol

The organization meets the expectations of the Universal Protocol.

## UP.01.01.01

Conduct a pre-procedure verification process.

**Rationale for UP.01.01.01**

The pre-procedure verification is an ongoing process of information gathering and verification, beginning with the decision to perform a procedure, continuing through all settings and interventions involved in the pre-procedure preparation of the [patient], up to and including the time-out just before the start of the procedure.

The purpose of the pre-procedure 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.

Missing information or discrepancies are addressed before starting the procedure.

**Elements of Performance for UP.01.01.01**

1 Verification of the correct person, correct site, and correct procedure occurs at the following times:
- At the time 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, whether elective or emergent.
- Before the patient leaves the pre-procedure area or enters the procedure room.
- Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers) at the time of, and during, the procedure.
- With the patient involved, awake and aware, if possible.

2 When the patient is in the pre-procedure area, immediately prior to moving the patient to the procedure room, a checklist (for example, paper, electronic, or other medium such as a wall-mounted white-board) is used to review and verify that the following items are available and accurately matched to the patient:
- Relevant documentation (for example, history and physical, nursing assessment, and pre-anesthesia assessment).
- Accurately completed, and signed, procedure consent form.
- Correct diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly labeled.
- Any required blood products, implants, devices and/or special equipment for the procedure.

## UP.01.02.01

Mark the procedure site.

**Rationale for UP.01.02.01**

Marking the procedure site allows staff to identify without ambiguity the intended site for the procedure.

**Elements of Performance for UP.01.02.01**

1 For all procedures involving incision or percutaneous puncture or insertion, the intended procedure site is marked. The marking takes into consideration laterality, the surface (flexor, extensor), the level (spine), or specific digit or lesion to be treated.
Note: For procedures that involve laterality of organs but the incision(s) or approaches may be from the mid-line or from a natural orifice, the site is still marked and the laterality noted.

2 The procedure site is initially marked before the patient is moved to the location where the procedure will be performed and takes place with the patient involved, awake and aware, if possible.

3 The procedure site is marked by a licensed independent practitioner or other provider who is privileged or permitted by the hospital to perform the intended surgical or non-surgical invasive procedure. This individual will be involved directly in the procedure and will be present at the time the procedure is performed.
Note: Final confirmation and verification of the site mark takes place during the time-out.

4 The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.

5 The mark addresses the following:
- Is made at or near the procedure site or the incision site. Other non-procedure site(s) are not marked unless necessary for some other aspect of care.
- Includes, preferably, the surgeon's or proceduralist's initials, with or without a line representing the proposed incision.
- Is made using a marker that is sufficiently permanent to remain visible after completion of the skin prep and sterile draping. Adhesive site markers are not to be used as the sole means of marking the site.
- Is positioned to be visible after the patient has his or her skin prepped, is in his or her final position, and sterile draping is completed.

6 For spinal procedures, in addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.

7 A defined, alternative process is in place for patients who refuse site marking or who cannot easily be marked under the following conditions:
- For cases in which it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, premature infants), an alternative method for visually identifying the correct side and site is used. For example, the hospital may place a temporary, unique wrist band on the side of the procedure containing the patient's name, and use a second identifier for the intended procedure and site.
- For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side is indicated by a mark at or near the insertion site, and remains visible after completion of the skin prep and sterile draping.
- For interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion).
- For teeth, the operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.
- For premature infants, for whom the mark may cause a permanent tattoo.

## UP.01.03.01

A time-out is performed immediately prior to starting procedures.

**Rationale for UP.01.03.01**

The purpose of the time-out immediately before starting the procedure is to conduct a final assessment that the correct [patient], site, positioning, and procedure are identified and that, as applicable, all relevant documents, related information, and necessary equipment are available.

The time-out is consistently initiated by a designated member of the team and includes active communication among all relevant members of the procedure team. It is conducted in a standardized fail-safe mode (that is, the procedure is not started until all questions or concerns are resolved).

**Elements of Performance for UP.01.03.01**

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|---|---|
| 1 | The time-out is conducted prior to starting the procedure and, ideally, prior to the introduction of the anesthesia process (including general/regional anesthesia, local anesthesia, and spinal anesthesia), unless contraindicated. |
| 2 | The time-out has the following characteristics:<br>- It is standardized (as defined by the hospital).<br>- It is initiated by a designated member of the team.<br>- It involves the immediate members of the procedure team including the proceduralist(s), the anesthesia providers, the circulating nurse, the operating room technician, and other active participants as appropriate for the procedure, who will be participating in the procedure at its inception.<br>- It involves interactive verbal communication between all team members, and any team member is able to express concerns about the procedure verification.<br>- It includes a defined process for reconciling differences in responses. |
| 3 | During the time-out, other activities are suspended, to the extent possible without compromising patient safety, so that all relevant members of the team are focused on the active confirmation of the correct patient, procedure, site, and other critical elements. |
| 4 | When two or more procedures are being performed on the same patient, a time-out is performed to confirm each subsequent procedure before it is initiated. |
| 5 | The time-out addresses the following:<br>- Correct patient identity.<br>- Confirmation that the correct side and site are marked.<br>- An accurate procedure consent form.<br>- Agreement on the procedure to be done.<br>- Correct patient position.<br>- Relevant images and results are properly labeled and appropriately displayed.<br>- The need to administer antibiotics or fluids for irrigation purposes. (See also NPSG.07.05.01, EP 7)<br>- Safety precautions based on patient history or medication use. |

6 The completed components of the Universal Protocol and time-out are clearly documented.