

2008 National Patient Safety Goals Hospital

National Patient Safety Goals

This chapter addresses the 2008 National Patient Safety Goals, requirements, and implementation expectations. The purpose of The Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care, the goals generally focus on system-wide solutions, wherever possible.

A broadly representative Sentinel Event Advisory Group works with Joint Commission staff on a continuing basis to prioritize and develop goals, requirements, and implementation expectations. As part of this development process, candidate goals, requirements, and implementation expectations are sent to the field for review and comment. The Advisory Group annually recommends selected existing and new goals, requirements, and implementation expectations to the Joint Commission's Board of Commissioners for review and approval.

If an organization thinks that an alternative approach meets the intent of the requirement and wishes to implement such an alternative, the organization must obtain Joint Commission approval of the alternative. The Sentinel Event Advisory Group also assists the Joint Commission in evaluating potential alternatives to goal requirements that have been suggested by individual organizations.

Organizations providing care, treatment, and services relevant to these goals are responsible for implementing the applicable requirements or effective alternatives. Compliance with these requirements is assessed throughout the accreditation cycle, through on-site surveys, and the Periodic Performance Review (PPR).¹ When an organization does not fully comply with a requirement, the organization will be assigned a requirement for improvement in the same way that noncompliance with an element of performance generates a requirement for improvement at a standard. All requirements for improvement must be addressed in an Evidence of Standards Compliance (ESC) Report. Failure to resolve a requirement for improvement affects an organization's accreditation decision, which could ultimately lead to a loss of accreditation.

The Joint Commission provides guidance on how to effectively comply with each goal's requirements. This guidance includes detailed answers to Frequently Asked Questions (FAQs), which are posted on the Joint Commission Web site (<http://www.jointcommission.org>).

Goal 1

¹ For those programs required to complete a PPR.

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Improve the accuracy of [patient] identification.

Requirement 1A

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

Rationale for Requirement 1A

Wrong-[patient] errors occur in virtually all aspects 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.

Implementation Expectations for Requirement 1A:

(M) C 1. Two [patient] identifiers are used when administering medications or blood products

(M) A 2. Two [patient] identifiers are used when collecting blood samples and other specimens for clinical testing

(M) C 3. Two [patient] identifiers are used when providing other treatments or procedures

A 4. The [patient's] room number or physical location is not used as an identifier.

(M) A 5. Containers used for blood and other specimens are labeled in the presence of the [patient].

Goal 2

Improve the effectiveness of communication among caregivers.

Requirement 2A

For verbal or telephone orders or for telephonic reporting of critical test results, verify 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 Requirement 2A

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

Implementation Expectation for Requirement 2A

(M) C 1. The receiver of the information **writes** down the complete order or test result or enters it into a computer.

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(M) C 2. The receiver of the information **reads** back the order or test result.

(M) C 3. The receiver of the information **receives** confirmation from the individual who gave the order or test result.

Requirement 2B

Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

Implementation Expectations for Requirement 2B

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

A 2. The list of abbreviations 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)²
- Lack of leading zero (.X mg)
- MS
- MSO₄
- MgSO₄

(M) C 3. The organization implements the “do not use” list and applies this list to all orders and all medication-related documentation when handwritten or entered as free text into a computer.

A 4. Preprinted forms do not include any abbreviations identified as not to be used.

Requirement 2C

Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical tests and critical results and values.

Implementation Expectations for Requirement 2C

A 1. The organization defines critical tests and critical results and values.

² **Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

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A 2. The organization defines the acceptable length of time between the ordering of critical tests and reporting the critical tests and critical results-and values.

A 3. The organization defines the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed care giver.

A 4. The organization collects data on the timeliness of reporting critical tests and critical results and values.

A 5. The organization assesses the data and determines whether there is a need for improvement.

A 6. The organization takes appropriate action to improve and measure the effectiveness of those actions.

Requirement 2D Not applicable

Requirement 2E

Implement a standardized approach to “hand-off” communications, including an opportunity to ask and respond to questions.

Rationale for Requirement 2E

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.

In health care there are numerous types of [patient] hand offs, including but not limited to nursing shift changes, physicians transferring complete responsibility for a [patient], physicians transferring on-call responsibility, 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, critical laboratory and radiology results sent to physician offices.

Implementation Expectations for Requirement 2E

(M) C 1. The organization’s process for effective “hand off” communication includes: Interactive communications allowing for the opportunity for questioning between the giver and receiver of [patient] information.

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(M) C 2. The organization's process for effective "hand off" communication includes: Up-to-date information regarding the [patient's] care, treatment and services, condition and any recent or anticipated changes.

(M) C 3. The organization's process for effective "hand off" communication includes: A process for verification of the received information, including repeat-back or read-back, as appropriate.

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

(M) C 5. Interruptions during hand offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

Goal 3 Improve the safety of using medications.

**Requirement 3A
Not applicable**

**Requirement 3B
Not applicable**

Requirement 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.

Implementation Expectations for Requirement 3C

A 1. Identify a list of look-alike/sound-alike (LASA) drugs used by the organization (the list must include a minimum of 10 look-alike/sound-alike drug combinations selected from the tables of LASA drugs posted on the Joint Commission website).

A 2. Review the list of look-alike/sound-alike drugs used by the organization at least annually.

A 3. The organization takes action to prevent errors involving the interchange of these drugs.

Requirement 3D

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

Rationale for Requirement 3D

This risk reduction activity is consistent with safe medication practices and addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings.

Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. Medications or other solutions in unlabeled containers are unidentifiable. This unsafe practice neglects basic principles of medication management safety yet has been routine in many organizations with respect to medications transferred to the sterile field.

Implementation Expectations for Requirement 3D

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

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

A 3. Labels include the drug 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.

(M) C 4. All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

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

A 6. Any medications or solutions found unlabeled are immediately discarded.

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

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

(M) C 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.

Anticoagulation Therapy

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Requirement 3E

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

Note: This requirement applies only to organizations that provide anticoagulation therapy.

Rationale for Requirement 3E:

Anticoagulation is a high risk treatment, which commonly leads to adverse drug events due to the complexity of dosing these medications, monitoring their effects, and ensuring patient compliance with outpatient therapy. The use of standardized practices that include patient involvement can reduce the risk of adverse drug events associated with the use of heparin (unfractionated), low molecular weight heparin (LMWH), warfarin, and other anticoagulants.

Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing (“milestones”) at 3, 6, and 9 months in 2008, with the expectation of full implementation by January 1, 2009.

A 1. As of April 1, 2008, the [organization]’s leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG Requirement 3E.

A 2. As of July 1, 2008, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG Requirement 3E by January 1, 2009.

A 3. As of October 1, 2008, pilot testing in at least one clinical unit is under way.

A 4. As of January 1, 2009, the process is fully implemented across the organization.

The Implementation Expectations that will apply beginning January 1, 2009, are provided below.

Implementation Expectations for 3E:

A 1. The organization implements a defined anticoagulant management program to individualize the care provided to each patient receiving anticoagulant therapy.

A 2. To reduce compounding and labeling errors, the organization uses **ONLY** oral unit dose products and pre-mixed infusions, when these products are available.

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(M) C 3. When pharmacy services are provided by the organization, warfarin is dispensed for each patient in accordance with established monitoring procedures.

(M) C 4. The organization 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 drug interactions.

(M) A 5. For patients being started 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.

(M) C 6. When dietary services are provided by the organization, the service is notified of all patients receiving warfarin and responds according to its established food/drug interaction program.

A 7. When heparin is administered intravenously and continuously, the organization uses programmable infusion pumps.

(M) C 8. The organization has a policy that addresses baseline and ongoing laboratories tests that are required for heparin and low molecular weight heparin therapies.

(M) C 9. The organization provides education regarding anticoagulation therapy to prescribers, staff, patients, and families.

(M) C 10. Patient/family education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions.

A 11. The organization evaluates anticoagulation safety practices (see MM.8.10).

**Goal 4
Not applicable**

**Goal 5
Not applicable**

**Goal 6
Not applicable**

**Goal 7
Reduce the risk of health care-associated infections.**

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Requirement 7A

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

Rationale for Requirement 7A

Compliance with the WHO Hand Hygiene Guidelines or CDC hand hygiene guidelines will reduce the transmission of infectious agents by staff to [patients], thereby decreasing the incidence of healthcare associated infections.

Implementation Expectation for Requirement 7A

(M) C 1. Comply with current WHO Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines³.

Requirement 7B

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

Rationale for Requirement 7B

A significant percentage of [patients] who unexpectedly die or suffer major permanent loss of function have healthcare 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 the questions (1) why did the [patient] acquire an infection and, (2) given the fact of the infection, why did the [patient] die or suffer permanent loss of function?

Implementation Expectations Requirement 7B

(M) C 1. The organization 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, conducts a root cause analysis).

A 2. The root cause analysis addresses the management of the [patient] before and after the identification of infection.

Goal 8

Accurately and completely reconcile medications across the continuum of care.

Requirement 8A

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

Rationale for Requirement 8A

³ Organizations are required to comply with all 1A, 1B, 1C CDC or WHO guidelines.

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[Patients] are most at risk during transitions in care (hand-offs) across settings, services, providers, or levels of care. The development, reconciliation and communication of an accurate medication list throughout the continuum of care is essential in the reduction of transition-related adverse drug events.

Implementation Expectations for Requirement 8A

(M) C 1. The organization, with the [patient]'s involvement, creates a complete list of the [patient]'s current medications at admission/entry.

(M) C 2. The medications ordered for, administered to, or dispensed to the [patient] while under the care of the organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved.

Requirement 8B A complete list of the [patient's] medications is communicated to the next provider of service when a [patient] is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the organization.

Implementation Expectations for Requirement 8B

(M) C 1. The [patient]'s accurate medication reconciliation list (complete with medications prescribed by the first provider of service) is communicated to the next provider of service, whether it be within or outside the organization

(M) C 2. The next provider of service checks the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.

(M) C 3. The complete list of medications is also provided to the [patient] on discharge from the organization.

Goal 9

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

Requirement 9B

Implement a fall reduction program including an evaluation of the effectiveness of the program.

Rationale for Requirement 9B

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, its [patients'] risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and

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balance screening, walking aids, assistive technologies and protective devices assessment and environmental assessments.

Implementation Expectations for Requirement 9B

A 1. The organization establishes a fall reduction program.

(M) C 2. The fall reduction program includes an evaluation as appropriate to the [patient] population, settings and services provided.

A 3. The fall reduction program includes interventions to reduce the [patient]'s fall risk factors.

(M) C 4. Staff receive education and training for the fall reduction program

(M) C 5. The [patient] and [patient]'s family is educated on the fall reduction program and any individualized fall reduction strategies.

A 6. The fall reduction program is evaluated to determine the effectiveness of the program. (Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.)

**Goal 10
Not applicable**

**Goal 11
Not applicable**

**Goal 12
Not applicable**

**Goal 13
Encourage [patients]' active involvement in their own care as a [patient] safety strategy.**

Requirement 13A

Define and communicate the means for [patients] and their families to report concerns about safety and encourage them to do so.

Rationale for Requirement 13A

Communication with [patients] and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When [patients] know what to expect, they are more aware of possible errors and choices. [Patients] can be an important source of information about potential adverse events and hazardous conditions.

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Implementation Expectation for Requirement 13A

(M) C 1.

[Patients] and families are educated on methods available to report concerns related to care, treatment, services and [patient] safety issues.

(M) C 2.

The organization encourages [patient]s and their families to report concerns about safety.

Goal 14

Not applicable

Goal 15

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

Rationale for Goal 15:

Probabilistic risk assessment has been used to assess the designs of high hazard systems such as chemical engineering plants and space initiatives. Probabilistic risk assessment looks at events that contributed to adverse outcomes. Healthcare has the ability to identify those areas of high risk potential based on previous sentinel events and other data.

Requirement 15A

The organization identifies [patients] 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 Requirement 15A

Suicide ranks as the eleventh most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #1 most frequently reported type of sentinel event since the inception of the Joint Commission's Sentinel Event Policy in 1996. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important first step in protecting and planning the care of these at-risk individuals.

Implementation Expectations for Requirement 15A

(M) C 1. The risk assessment includes identification of specific factors and features that may increase or decrease risk for suicide.

(M) C 2. The [patient]'s immediate safety needs and most appropriate setting for treatment are addressed.

(M) C 3. The organization provides information such as a crisis hotline to individuals and their family members for crisis situations.

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Recognition and Response to Changes in Patient's Conditions

Goal 16

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

Requirement 16A

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 Requirement 16A

A significant number of critical inpatient events are preceded by warning signs for an average of 6 to 8 hours. Critical events such as cardiopulmonary and respiratory arrests or changes in patient's vital signs are estimated to occur in 4% to 17% of inpatient admissions. Early response by a specially trained individual(s) to changes in a patient's condition may reduce cardiopulmonary arrests and patient mortality.

Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing ("milestones") at 3, 6, and 9 months in 2008, with the expectation of full implementation by January 1, 2009.

A 1. As of April 1, 2008, the [organization]'s leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG Requirement 16A.

A 2. As of July 1, 2008, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG Requirement 16A by January 1, 2009.

A 3. As of October 1, 2008, pilot testing in at least one clinical unit is under way.

A 4. As of January 1, 2009, the process is fully implemented across the organization.

The Implementation Expectations that will apply beginning January 1, 2009, are provided below.

Implementation Expectations for Requirement 16A

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

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

A 3. The organization empowers staff, patients, and/or families to request additional assistance when they have a concern about the patient's condition.

(M) C 4. Formal education for urgent response policies and practices is conducted with the people who may request assistance and the people who may respond to those requests.

A 5. The organization measures the utility and effectiveness of the intervention(s) employed.

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

Universal Protocol

Wrong site, wrong procedure, wrong person surgery can be prevented. This universal protocol is intended to achieve that goal. It is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

In developing this protocol, consensus was reached on the following principles:

- Wrong site, wrong procedure, wrong person surgery can and must be prevented.
- A robust approach—using multiple, complementary strategies—is necessary to achieve the goal of eliminating wrong site, wrong procedure, wrong person surgery.
 - Active involvement and effective communication among all members of the surgical team is important for success.
 - To the extent possible, the patient (or legally designated representative) should be involved in the process.
 - Consistent implementation of a standardized approach using a universal, consensus-based protocol will be most effective.
 - The protocol should be flexible enough to allow for implementation with appropriate adaptation when required to meet specific patient needs.
 - A requirement for site marking should focus on cases involving right/left distinction, multiple structures (fingers, toes), or levels (spine).
 - The universal protocol should be applicable or adaptable to all operative and other invasive procedures that expose patients to harm, including procedures done in settings other than the operating room.

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In concert with these principles, the following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, wrong person surgery:

- Pre-operative verification process
 - Purpose: To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.
 - Process: An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the "time out" just before the start of the procedure.
- Marking the operative site
 - Purpose: To identify unambiguously the intended site of incision or insertion.
 - Process: For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.
- "Time out" immediately before starting the procedure
 - Purpose: To conduct a final verification of the correct patient, procedure, site and, as applicable, implants.
 - Process: Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a "fail-safe" mode, i.e., the procedure is not started until any questions or concerns are resolved.

Universal Protocol

The organization fulfills the expectations set forth in the Universal Protocol

UP Requirement 1A

Conduct a pre-operative verification process as described in the Universal Protocol

Implementation Expectations

(M) A 1. Verification of the correct person, procedure, and site should occur during the following (as applicable):

- At the time the surgery/procedure is scheduled.
- At the time of admission or entry into the facility.

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- Anytime the responsibility for care of the patient is transferred to another caregiver.
- With the patient involved, awake and aware, if possible.
- Before the patient leaves the preoperative area or enters the procedure/surgical room.

(M) A 2. The following is reviewed prior to the start of the procedure:

- Relevant documentation (e.g. H&P, consent).
- Relevant images, properly labeled and displayed.
- Any required implants and special equipment.

UP Requirement 1B

Mark the operative site as described in the Universal Protocol

Implementation Expectations

(M) C 1. Make the mark at or near the incision site; do not mark any non-operative site(s) unless necessary for some other aspect of care.

A 2. The mark must be unambiguous. (Note: for example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous.)

(M) C 3. The mark must be positioned to be visible after the patient is prepped and draped.

A 4. The method of marking and type of mark should be consistent throughout the organization.

(M) C 5. At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). (Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level).

(M) C 6. The person performing the procedure should do the site marking.

(M) C 7. Marking must take place with the patient involved, awake and aware, if possible.

UP Requirement 1C

Conduct a “time out” immediately before starting the procedure as described in the Universal Protocol

Implementation Expectations

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(M) C 1. The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

(M) A 2. The process must involve the entire operative team, use active communication, and must, at least, include:

- Correct [patient] identity.
- Correct side and site
- Agreement on the procedure to be done.
- Correct [patient] position.
- Availability of correct implants and any special equipment or special requirements.

(M) C 3. The process is briefly documented, such as in a checklist (Note: the organization should determine the type and amount of documentation.)

A 4. The organization should have processes and systems in place for reconciling differences in staff responses during the final verification process.

Guidelines for the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™

These guidelines provide detailed implementation requirements, exemptions and adaptations for special situations.

1. Pre-operative verification process

Verification of the correct person, procedure, and site should occur (as applicable):

- At the time the surgery/procedure is scheduled.
- At the time of admission or entry into the facility.
- Anytime the responsibility for care of the patient is transferred to another caregiver.
- With the patient involved, awake and aware, if possible.
- Before the patient leaves the preoperative area or enters the procedure/surgical room.

A preoperative verification checklist may be helpful to ensure availability and review of the following, prior to the start of the procedure:

- Relevant documentation (e.g. H&P, consent).
- Relevant images, properly labeled and displayed.
- Any required implants and special equipment.

2. Marking the operative site

- Make the mark at or near the incision site. Do NOT mark any non-operative site(s) unless necessary for some other aspect of care.

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- The mark must be unambiguous (e.g., use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous).
- The mark must be positioned to be visible after the patient is prepped and draped.
- The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.
- The method of marking and type of mark should be consistent throughout the organization.
- At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level).
- The person performing the procedure should do the site marking.
- Marking must take place with the patient involved, awake and aware, if possible.
- Final verification of the site mark must take place during the “time out.”
- A defined procedure must be in place for patients who refuse site marking.

Exemptions:

- Single organ cases (e.g., Cesarean section, cardiac surgery).
- Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., cardiac catheterization).
- Teeth—BUT, indicate operative tooth name(s) on documentation *OR* mark the operative tooth (teeth) on the dental radiographs or dental diagram.
- Premature infants, for whom the mark may cause a permanent tattoo.

3. “Time out” immediately before starting the procedure

Must be conducted in the location where the procedure will be done, just before starting the procedure. It must involve the entire operative team, use active communication, be briefly documented, such as in a checklist (the organization should determine the type and amount of documentation) and must, at the least, include:

- Correct patient identity.
- Correct side and site.
- Agreement on the procedure to be done.
- Correct patient position.
- Availability of correct implants and any special equipment or special requirements.

The organization should have processes and systems in place for reconciling differences in staff responses during the “time out.”

4. Procedures for non-OR settings including bedside procedures.

- Site marking must be done for any procedure that involves laterality, multiple structures or levels (even if the procedure takes place outside of an OR).

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- Verification, site marking, and “time out” procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.
- Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a “time out” final verification still applies.