Some Changes Effective Immediately

The Joint Commission released its 2010 National Patient Safety Goals (NPSGs) in September for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, Medicare/Medicaid Certification–based long term care, and office-based surgery accreditation programs. The NPSGs were revised partly in response to concerns from the field about the resources needed to comply with NPSGs becoming more specific and detailed over time. The revisions include clarifying and streamlining certain elements of performance, moving some requirements to the standards, and deleting others (see the table on pages 20 and 21 for a summary of revisions).

Effective immediately, during the on-site survey, surveyors will not evaluate compliance with requirements that have been deleted. The remaining changes will be effective January 1, 2010. The 2010 NPSGs appear starting on page 22 of this issue and on The Joint Commission Web site at http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/.

The 2010 NPSGs reflect The Joint Commission’s continuing efforts to spotlight those topics that are of highest priority to patient safety and quality care. Decreasing the number of NPSGs allows organizations to focus their efforts on the most urgent issues. Moving a requirement to the standards means that it is no longer

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* The final, program-specific 2010 goals will also appear in 2009 Update 2 and the 2010 accreditation manuals.
necessary to “spotlight” the issue in the NPSGs. The improvements, similar to the Standards Improvement Initiative, are intended to clarify language and ensure relevancy to the settings in which they apply.

The Joint Commission did not include the medication reconciliation goal (NPSG 8) in these changes because it is still being evaluated and refined. Early this year, The Joint Commission suspended the scoring (although not the evaluation) of NPSG 8 during the on-site survey. Survey findings on this goal are not factored into organizations’ accreditation decisions nor are Requirements for Improvement generated (see March 2009 Perspectives, page 1). The Joint Commission conducted research on NPSG 8 this summer, including literature reviews, focus groups, and interviews with experts (see April 2009 Perspectives, page 1) and expects to send a revised version of the NPSG available to field review in early 2010 and for approval by the Standards and Survey Procedures Committee in spring 2010.

In addition, disease-specific care (DSC) certification will no longer have its own set of NPSGs because of the recent decision to limit DSC certification to programs in Joint Commission–accredited organizations only (see August 2009 Perspectives, page 3). The parent organizations of DSC programs will be responsible for making sure that the DSC program meets applicable NPSGs.

Finally, while no new 2010 NPSGs have been developed, on January 1, 2010, organizations will be expected to have fully implemented the requirements for NPSG.07.03.01 through NPSG.07.05.01 related to health care–associated infections (introduced incrementally in 2009). Also, NPSG.07.04.01 on central line infections was inadvertently left out in the 2009 Comprehensive Accreditation Manual for Long Term Care as being applicable to Medicare-certified long term care organizations. That goal will be effective for these organizations on July 1, 2010.

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### Changes to the 2010 National Patient Safety Goals

#### Deletions effective immediately; all other changes effective January 1, 2010

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Abbreviations: AHC, ambulatory health care; BHC, behavioral health care; CAH, critical access hospital; HAP, hospital; LAB, laboratory; LTC, long term care; LT2, Medicaid/Medicare Certification–based long term care; OME, home care.

Key: NPSG, retained in the goals; Delete, redundant or non-essential; Move, relocate to standards.

* Effective July 1, 2010, for Medicaid/Medicare Certification–based long term care.
† This goal is not in effect at this time.
‡ See article on page 3 of this issue for more information on the changes to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™.
Goal 1: Improve the accuracy of [patient] identification.

**NPSG.01.01.01 [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]**

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

**BHC:** Treatments covered by this goal include high-risk interventions and certain high risk medications (for example, methadone). In some settings, use of visual recognition as an identifier is acceptable. Such settings include those that regularly serve an individual (for example, therapy) or serve only a few individuals (for example, a group home). These are settings in which the individual stays for an extended period of time, staff and populations served are stable, and individuals receiving care are well-known to staff.

**LTC, LT2:** At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician knows the resident, one identifier can be facial recognition.

**OME:** In the home care setting, patient identification is less prone to error than in other settings. At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician "knows" the patient, one of the identifiers can be facial recognition. In the home, the correct address is also confirmed. The patient’s confirmed address is an acceptable identifier when used in conjunction with another individual-specific identifier.

**Rationale for NPSG.01.01.01 [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]**

[AHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]: Wrong-[patient] errors occur in virtually all stages of diagnosis and treatment.

[BHC]: Errors involved in misidentification of the individual served can 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**

**C 1. [AHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]** Use at least two [patient] identifiers when administering [AHC, CAH, HAP, LTC, LT2, OBS, OME: medications.] [AHC, CAH, HAP, LAB, OBS, OME: blood, or blood components] when collecting blood samples and other specimens for clinical testing; and when providing [LAB: other] treatments or procedures. [AHC, CAH, HAP, LTC, LT2, OBS: The [patient]’s room number or physical location is not used as an identifier.] [AHC, CAH, HAP, OBS: (See also [AHC, CAH, HAP, LTC: MM.05.01.09, EPs 8 and 11] NPSG.01.03.01, EP 1)]

**BHC** Use at least two identifiers of the individual served when administering medications or collecting specimens for clinical testing. The room number or physical location of the individual served is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11)

**LAB:** Example of “other procedures” includes bone marrow aspirates.

**A 2. [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]** Label containers used for [AHC, CAH, HAP, LAB, OBS, OME: blood and other] specimens in the presence of the [patient]. [AHC, CAH, HAP, OBS: (See also NPSG.01.03.01, EP 1)]

**NPSG.01.03.01 [AHC, CAH, HAP, OBS]**

Eliminate transfusion errors related to [patient] misidentification.

**Elements of Performance for NPSG.01.03.01**

**A 1. [AHC, CAH, HAP, OBS]** 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. (See also NPSG.01.01.01, EPs 1 and 2)

**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.

**A 2. [AHC, CAH, HAP, OBS]** 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. [AHC, CAH, HAP, OBS]** When using a two-person verification process, the second individual conducting the iden-
Goal 2: Improve the effectiveness of communication among caregivers. [CAH, HAP, LAB]

NPSG.02.03.01 [CAH, HAP, LAB]
Report critical results of tests and diagnostic procedures on a timely basis.

Rationale for NPSG.02.03.01 [CAH, HAP, LAB]
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
A 1. [CAH, HAP, LAB] Implement procedures for managing the critical results of tests and diagnostic procedures.
   - 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

A 2. [CAH, HAP, LAB] Implement the procedures for managing the critical results of tests and diagnostic procedures.

A 3. [CAH, HAP, LAB] Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

Goal 3: Improve the safety of using medications. [AHC, CAH, HAP, LTC, LT2, OBS]

NPSG.03.04.01 [AHC, CAH, HAP, OBS]
Label all medications, medication containers, and other solutions on and off the sterile field 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
A 1. [AHC, CAH, HAP, OBS] 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.
   - 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.

A 2. [AHC, CAH, HAP, OBS] 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. [AHC, CAH, HAP, OBS] In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
   - Medication name
   - Strength
   - Quantity
   - Diluent and volume (if not apparent from the container)
   - Preparation date
   - 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 organization.

C 4. [AHC, CAH, HAP, OBS] 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.

A 5. [AHC, CAH, HAP, OBS] 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.

A 6. [AHC, CAH, HAP, OBS] Immediately discard any medication or solution found unlabeled.

A 7. [AHC, CAH, HAP, OBS] 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.

C 8. [AHC, CAH, HAP, OBS] 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.
2010 National Patient Safety Goals (continued)

NPSG.03.05.01 [AHC, CAH, HAP, LTC, LT2]
Reduce the likelihood of [patient] harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to [organization]s 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 [organization]ization) 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 [AHC, CAH, HAP, LTC, LT2]
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 [patient]s 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 [patient]s 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), warfarin, and low molecular weight heparin.

Elements of Performance for NPSG.03.05.01

A 1. [CAH, HAP, LTC, LT2] Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. ∆

Note: For pediatric [patient]s, prefilled syringe products should be used only if specifically designed for children.

C 2. [AHC, CAH, HAP, LTC, LT2] Use approved protocols for the initiation and maintenance of anticoagulant therapy. ☑

A 3. [AHC, CAH, HAP, LTC, LT2] Before starting a [patient] on warfarin, assess the [patient]’s baseline coagulation status; for all [patient]s 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. ☑

A 4. [CAH, HAP, LTC, LT2] Use authoritative resources to manage potential food and drug interactions for [patient]s receiving warfarin. ☑

A 5. [CAH, HAP, LTC, LT2] When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing. ☑

A 6. [CAH, HAP, LTC, LT2] A written policy addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.

C 7. [AHC, CAH, HAP, LTC, LT2] Provide education regarding anticoagulant therapy to [staff], [patient]s, 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

A 8. [AHC, CAH, HAP, LTC, LT2] Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.

Goal 7: Reduce the risk of health care–associated infections. [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]

NPSG.07.01.01 [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]
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.

[BHC: Note: This element of performance applies only to organizations that provide physical care.]

Rationale for NPSG.07.01.01 [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]

[AHC, BHC, CAH, HAP, LAB, LTC, OBS, OME: 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 [patient]s, thereby decreasing the incidence rates 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. [BHC: Following safe hand hygiene practices is important in all organizations; however, the risk to individuals served increases when there is physical contact. In these situations, it is more important to follow formal hand hygiene guidelines. This requirement, therefore, applies only to organizations that provide physical care.]

Elements of Performance for NPSG.07.01.01
A 1. [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME] 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. [AHC, BHC, CAH, HAP, LAB, LTC, OBS, OME: (See also IC.01.04.01, EP 5)] [BHC: Note: This element of performance applies only to organizations that provide physical care.]

A 2. [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME] Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 3) [BHC: Note: This element of performance applies only to organizations that provide physical care.]

A 3. [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME] Improve compliance with hand hygiene guidelines based on established goals. [BHC: Note: This element of performance applies only to organizations that provide physical care.]

NPSG.07.03.01 [CAH, HAP]
Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in [HAP: acute care] [organization]s. [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME: (See also IC.02.01.01, EP 3) [CAH, HAP: 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 enterococcus (VRE), and multidrug-resistant gram-negative bacteria.]

Rationale for NPSG.07.03.01 [CAH, HAP]
[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 multidrug-resistant organisms (MDROs). [CAH, HAP: 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 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
A 1. [CAH, HAP] Conduct periodic risk assessments (in time frames defined by the [organization]) for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1–5) [CAH, HAP: Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the [organization].]

C 2. [CAH, HAP] 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. [CAH, HAP: Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the [organization].]

C 3. [CAH, HAP] Educate [patient]s, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection strategies. [CAH, HAP: Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the [organization].]

A 4. [CAH, HAP] Implement a surveillance program for multidrug-resistant organisms based on the risk assessment. [CAH, HAP: Note: Surveillance may be targeted rather than [organization]-wide.]

A 5. [CAH, HAP] 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

A 6. [CAH, HAP] Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

C 7. [CAH, HAP] 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).

A 8. [CAH, HAP] When indicated by the risk assessment, implement a laboratory-based alert system that identifies new [patient]s with multidrug-resistant organisms. [CAH, HAP: Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.]

A 9. [CAH, HAP] When indicated by the risk assessment, implement an alert system that identifies readmitted or

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transferred [patient]s who are known to be positive for multidrug-resistant organisms.  

**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 [organization] may define its own parameters in terms of time and clinical manifestation to determine which re-admitted [patient]s require isolation.

**NPSG.07.04.01 [CAH, HAP, LTC]**
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**

**C 1. [CAH, HAP, LTC]** 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. [CAH, HAP]** Prior to insertion of a central venous catheter, educate [patient]s and, as needed, their families about central line–associated bloodstream infection prevention. [ ]

**C 3. [CAH, HAP]** 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). [ ]

**A 4. [CAH, HAP]** 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 [organization], and this infection surveillance activity is [organization]-wide, not targeted.

**A 5. [CAH, HAP]** 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.

**C 6. [CAH, HAP]** Use a catheter checklist and a standardized protocol for central venous catheter insertion. [ ]

**C 7. [CAH, HAP]** Perform hand hygiene prior to catheter insertion or manipulation. [ ]

**C 8. [CAH, HAP]** For adult [patient]s, do not insert catheters into the femoral vein unless other sites are unavailable. [ ]

**C 9. [CAH, HAP]** Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters. [ ]

**C 10. [CAH, HAP]** Use a standardized protocol for sterile barrier precautions during central venous catheter insertion. [ ]

**C 11. [CAH, HAP]** Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in [patient]s over 2 months of age, unless contraindicated. [ ]

**C 12. [CAH, HAP, LTC]** Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. [ ]

**C 13. [CAH, HAP, LTC]** Evaluate all central venous catheters routinely and remove nonessential catheters. [ ]

**NPSG.07.05.01 [AHC, CAH, HAP, OBS]**
Implement evidence-based practices for preventing surgical site infections.

**Elements of Performance for NPSG.07.05.01**

**C 1. [AHC, CAH, HAP, OBS]** 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 2. [AHC, CAH, HAP, OBS]** Educate [patient]s, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention. [ ]

**C 3. [AHC, CAH, HAP, OBS]** 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). [ ]

**A 4. [AHC, CAH, HAP, OBS]** 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 [organization].
- 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 [organization]’s risk assessment.

**A 5. [AHC, CAH, HAP, OBS]** 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 [organization]’s measurement strategies follow evidence-based guidelines.

Note: Surveillance may be targeted to certain procedures based on the [organization]’s risk assessment.

A 6. [AHC, CAH, HAP, OBS] Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

C 7. [AHC, CAH, HAP, OBS] Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to evidence-based best practices. 

A 8. [AHC, CAH, HAP, OBS] When hair removal is necessary, use clippers or depilatories.  

Note: Shaving is an inappropriate hair removal method.

Goal 8: Accurately and completely reconcile medications across the continuum of care. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]

NPSG.08.01.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]  
A process exists for comparing the [patient]’s current medications with those ordered for the [patient] while under the care of the [organization].  

Note: This standard is not in effect at this time.

Rationale for NPSG.08.01.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]  
[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

C 1. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] At the time the [patient] enters the [organization] 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, as needed, the family are involved in creating this list.  

Note: This element of performance is not in effect at this time.

C 2. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] The medications ordered for the [patient] while under the care of the [organization] are compared to those on the list created at the time of entry to the [organization] or admission.  

Note: This element of performance is not in effect at this time.

C 3. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the [patient] is under the care of the [organization].  

Note: This element of performance is not in effect at this time.

C 4. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] When the [patient]’s care is transferred within the [organization] [CAH, HAP: (for example, from the ICU to a floor)] the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication.  

Note 1: Updating the status of a [patient]’s medications is also an important component of all [patient] care handoffs.  

Note 2: This element of performance is not in effect at this time.

NPSG.08.02.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]  
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 to go directly to his or her home, the complete and reconciled list of medications is provided to the [patient]’s known primary care provider, the original referring provider, or a known next provider of service.

Note 1: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the [patient] and, as needed, the family the list of reconciled medications is sufficient.  

Note 2: This standard is not in effect at this time.

Rationale for NPSG.08.02.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]  
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

C 1. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] The [patient]’s most current reconciled medication list is communicated to the next provider of service, either within or outside the [organization]. The communication between providers is documented.  

Note: This element of performance is not in effect at this time.

C 2. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] At the time of transfer, the transferring [organization] informs the
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next provider of service how to obtain clarification on the list of reconciled medications.

Note: This element of performance is not in effect at this time.

NPSG.08.03.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]
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, as needed, the family, and the list is explained to the [patient] and/or family.

Note: This standard is not in effect at this time.

Rationale for NPSG.08.03.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]
The accurate communication of the [patient]’s medication list to the [patient] and, as needed, the family, 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].

Element of Performance for NPSG.08.03.01
C 1. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] When the [patient] leaves the [organization]’s care, the current list of reconciled medications is provided and explained to the [patient] and, as needed, the family. This interaction is documented.

Note 1: [patient]s and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

Note 2: This element of performance is not in effect at this time.

NPSG.08.04.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]
In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

Note 1: This requirement does not apply to [organization]s that do not administer medications. It may be important for health care organizations to know which types of medications their [patient]s are taking because these medications could affect the [care, treatment, and services] provided.

Note 2: This standard is not in effect at this time.

Rationale for NPSG.08.04.01 [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME]
A number of [patient] care settings exist in which medications are not used, are used minimally, or are 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
C 1. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] The [organization] 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, [CAH, HAP, OBS]: intravenous contrast media, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.

Note: This element of performance is not in effect at this time.

C 2. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] When only short-term medications (for example, a preprocedure 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, as needed, the family are provided with a list containing the short-term medication additions that the [patient] will continue after leaving the [organization].

Note 1: This list of new short-term medications is not considered to be part of the original, known, and current medication list. When [patient]s 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.

Note 2: This element of performance is not in effect at this time.

C 3. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] In these settings, a complete, documented medication reconciliation process is used when: Any new long-term (chronic) medications are prescribed.

Note: This element of performance is not in effect at this time.

C 4. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] 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.

Note: This element of performance is not in effect at this time.

C 5. [AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME] In these settings, a complete, documented medication reconciliation process is used when: The [patient] is [AHC, CAH, HAP, LTC, LT2, OBS, OME]: required to be] subse-
Goal 9: Reduce the risk of [patient] harm resulting from falls. [LTC, LT2, OME]

NPSG.09.02.01 [LTC, LT2, OME]
Reduce the risk of falls.

Rationale for NPSG.09.02.01 [LTC, LT2, OME]
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

A 1. [LTC, LT2, OME] Create a written plan for the identification of risk for and prevention of pressure ulcers. [HAP: Note: This requirement applies only to psychiatric [organization]s and [patient]s being treated for emotional or behavioral disorders in general [organization]s.]

B 2. [LTC, LT2, OME] Implement interventions to reduce falls based on the patient's assessed risk.

C 3. [LTC, LT2, OME] Educate staff on the fall reduction program in time frames determined by the organization.

C 4. [LTC, LT2, OME] Educate the patient and, as needed, the family on any individualized fall reduction strategies.

A 5. [LTC, LT2, OME] Evaluate the effectiveness of all fall reduction activities including assessment, interventions and education.

Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number and severity of fall-related injuries.

Goal 14: Prevent health care–associated pressure ulcers (decubitus ulcers). [LTC, LT2]

NPSG.14.01.01 [LTC, LT2]
Assess and periodically reassess each resident's risk for developing a pressure ulcer and take action to address any identified risks.

Rationale for NPSG.14.01.01 [LTC, LT2]
Pressure ulcers (decubiti) continue to be problematic in all health care settings. Most pressure ulcers can be prevented, and deterioration at Stage I can be halted. The use of clinical practice guidelines can effectively identify residents and define early intervention for prevention of pressure ulcers.

Elements of Performance for NPSG.14.01.01


B 2. [LTC, LT2] Perform an initial assessment at admission to identify residents at risk for pressure ulcers.

C 3. [LTC, LT2] Conduct a systematic risk assessment for pressure ulcers using a validated risk assessment tool such as the Braden Scale or Norton Scale.

C 4. [LTC, LT2] Reassess pressure ulcer risk at intervals defined by the organization.

C 5. [LTC, LT2] Take action to address any identified risks to the resident for pressure ulcers, including the following:

- Preventing injury to residents by maintaining and improving tissue tolerance to pressure in order to prevent injury
- Protecting against the adverse effects of external mechanical forces

A 6. [LTC, LT2] Educate staff on how to identify risk for and prevent pressure ulcers.

Goal 15: The [organization] identifies safety risks inherent in its [patient] population. [BHC, HAP, OME]

NPSG.15.01.01 [BHC, HAP]
Identify [patient]s at risk for suicide.

[HAP: Note: This requirement applies only to psychiatric [organization]s and [patient]s being treated for emotional or behavioral disorders in general [organization]s.]

Rationale for NPSG.15.01.01 [BHC, HAP]
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

C 1. [BHC, HAP] Conduct a risk assessment that identifies specific [patient] characteristics and environmental features that may increase or decrease the risk for suicide.

C 2. [BHC, HAP] Address the [patient]'s immediate safety needs and most appropriate setting for treatment.

C 3. [BHC, HAP] When a [patient] at risk for suicide leaves the care of the [organization], provide suicide prevention information (such as a crisis hotline) to the [patient] and his or her family.
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NPSG.15.02.01 [OME]
Identify risks associated with home oxygen therapy such as home fires.

Rationale for NPSG.15.02.01 [OME]
Many sentinel events reported by home care programs to The Joint Commission were due to a fire in the patient’s home. In each case, when patients were injured or killed as a result of a home fire, home oxygen was in use.

Elements of Performance for NPSG.15.02.01
C 1. [OME] Conduct a home oxygen safety risk assessment that addresses at least the following: ☐ ☐
   - Whether there are smoking materials in the home
   - Whether there are other fire safety risks in the home, such as the potential for open flames
   - Whether or not the home has functioning smoke detectors

Note: Further information about risks associated with home oxygen therapy and risk reduction strategies can be found in Sentinel Event Alert 17.

C 2. [OME] Inform the patient and family/caregiver of the findings of the safety risk assessment and educate the patient and family/caregiver about the causes of fire, precautions that can prevent fire-related injuries, and recommendations to address the specific identified risk. ☐ ☐

C 3. [OME] Assess the patient’s level of comprehension of and compliance with identified risks and suggested interventions. ☐ ☐

Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery [AHC, CAH, HAP, OBS]

UP.01.01.01 [AHC, CAH, HAP, OBS]
Conduct a preprocedure verification process.

Rationale for UP.01.01.01 [AHC, CAH, HAP, OBS]
[organization] 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 [organization] 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
A 1. [AHC, CAH, HAP, OBS] Implement a preprocedure process to verify the correct procedure, for the correct [patient], at the correct site. ☐

Note: The [patient] is involved in the verification process when possible.

A 2. [AHC, CAH, HAP, OBS] 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: ☐

- 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 procedure

Note: 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].

A 3. [AHC, CAH, HAP, OBS] Match the items that are to be available in the procedure area to the [patient].

UP.01.02.01 [AHC, CAH, HAP, OBS]
Mark the procedure site.

Elements of Performance for UP.01.02.01
C 1. [AHC, CAH, HAP, OBS] 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. ☐

Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraop-
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C 2. [AHC, CAH, HAP, OBS] Mark the procedure site before the procedure is performed and, if possible, with the [patient] involved. ☒

C 3. [AHC, CAH, HAP, OBS] 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: ☒

- An individual in a medical residency 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 [A.P.R.N.] or physician assistant [P.A.]); who is familiar with the [patient]; and who will be present when the procedure is performed.

A 4. [AHC, CAH, HAP, OBS] The method of marking the site and the type of mark is unambiguous and is used consistently throughout the [organization]. ☒

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.

A 5. [AHC, CAH, HAP, OBS] ☒ A written, alternative process is in place for [patient]s who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum). ☒

Note: Examples of other situations that involve alternative processes include:

- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion)
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

UP.01.03.01 [AHC, CAH, HAP, OBS]
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]. An organization 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 [organization].

Elements of Performance for UP.01.03.01

A 1. [AHC, CAH, HAP, OBS] Conduct a time-out immediately before starting the invasive procedure or making the incision. ☒

A 2. [AHC, CAH, HAP, OBS] The time-out has the following characteristics:

- It is standardized, as defined by the [organization].
- 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.

A 3. [AHC, CAH, HAP, OBS] 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. [AHC, CAH, HAP, OBS] 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

C 5. [AHC, CAH, HAP, OBS] Document the completion of the time-out. ☒

Note: The [organization] determines the amount and type of documentation.