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 needed for accreditation. Continued on page 20

* The final, program-specific 2010 goals will also appear in 2009 Update 2 and the 2010 accreditation manuals.
This column informs you of developments and potential revisions that can affect your accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they were rejected at some point in the process.

APPROVED
- Revisions to the National Patient Safety Goals for 2010 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 programs
- Revisions for 2010 to the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™ for the ambulatory care, critical access hospital, and office-based surgery programs
- Revisions to align with the Centers for Medicare & Medicaid Services’ (CMS) requirements for the hospital program (see special CMS section in this issue, beginning on page 11)

IN COMMITTEE OR BOARD REVIEW
- Proposed revisions to align with the CMS requirements for the hospital program

CURRENTLY IN FIELD REVIEW
- Proposed revisions to the staffing effectiveness requirements for the hospital and long term care programs

CURRENTLY IN DEVELOPMENT

STANDARDS
- Proposed standards on communication and culturally competent patient-centered care for the hospital program
- Proposed revisions to the staffing effectiveness requirements for the hospital and long term care programs
- Proposed revisions to align with CMS rules for accrediting advanced imaging providers for the ambulatory care program
- Proposed revisions to the “Provision of Care, Treatment, or Services” chapter for the behavioral health care program

JOINT COMMISSION INTERNATIONAL
Field review notifications are sent out electronically as well as posted on the Joint Commission International (JCI) Web site at www.jointcommissioninternational.org. For JCI standards questions, please contact the associate director of Standards Development and Interpretation at jciaccreditation@jcrinc.com.

IN FIELD REVIEW AT JCI
- Revisions to international disease-specific care certification standards
Based on feedback from a recent field review, The Joint Commission revised the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™ for the hospital, critical access hospital, ambulatory care, and office-based surgery programs. While some changes will be effective January 1, 2010, others are effective immediately. For the remainder of 2009 on-site surveys, surveyors will not evaluate compliance with requirements that were eliminated but will review the EPs that were substantially modified. The following elements of performance (EPs) are affected:

- UP.01.01.01, EPs 1 and 2
- UP.01.02.01, EPs 1, 2, 3, and 7
- UP.01.03.01, EPs 1, 5, and 6

Given the diversity of organizations that need to follow the Universal Protocol, The Joint Commission intends for the revisions to address patient safety issues while allowing organizations flexibility in applying the requirements within existing work processes. The changes stem from concerns shared with The Joint Commission by accredited and professional organizations related to the practical implications of complying with modifications to the Universal Protocol that became effective January 1, 2009. These concerns focused primarily on the specificity of the requirements. An overview of the changes to the Universal Protocol appears in the box below. The revised Universal Protocol appears on pages 30 and 31 of this issue and on The Joint Commission Web site at http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/.

**Summary of Changes to the Universal Protocol for 2010**

- **Applicability:** The Universal Protocol applies to “all surgical and non-surgical invasive procedures.” This is a change from “all invasive procedures that put patients at more than minimal risk, regardless of the location within an organization.”

- **Pre-procedure verification (UP.01.01.01):** References to the location (pre-procedure area) and timing of the verification have been removed. The term checklist implied the need to document each step for each patient and is now replaced by reference to a standardized list to be used in the verification process. A note has been added clarifying that documentation of the use of the standardized list on a per-patient basis is not required, although it is expected that the list be used for every patient.

- **Site marking (UP.01.02.01):** The revised Universal Protocol requires that the procedure site be 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 a qualified individual who is permitted by the organization to participate in the procedure, is familiar with the patient, and will be present when the procedure is performed, including residents qualified through a medical residency program, licensed advanced practice registered nurses (APRNs), and physician assistants (PAs) who perform duties requiring collaboration or supervisory agreements with a licensed independent practitioner. This option is available when it is not feasible for the person responsible for the procedure to mark the site and takes into account the current position of The Joint Commission, National Quality Forum, World Health Organization, and American Academy of Orthopaedic Surgeons and the concern raised by the field that the current requirement is impractical under some circumstances. The Joint Commission will continue to gather input and data on this issue.

- **Alternative processes for site marking (UP.01.02.01):** The current Universal Protocol describes situations in which exceptions to site marking are allowed. The requirement was modified to allow organizations to develop alternative processes for site marking.

- **Time-out (UP.01.03.01):** The time-out will occur prior to incision or the start of the procedure. References in the current Universal Protocol to conducting the time-out before the provision of anesthesia were removed. The rationale states that the organization may do the time-out before providing anesthesia or may choose to do more than one time-out. The list of issues to address in the time-out was shortened to focus on the correct patient, procedure, and site.
The Joint Commission has edited Infection Prevention and Control (IC) Standard IC.02.02.01 and its Elements of Performance (EP) 1 and 2 for ambulatory care, behavioral health care, critical access hospitals, home care, hospitals, laboratories, long term care, and office-based surgery. These changes are effective immediately. A new rationale for Standard IC.02.02.01, and revisions to EPs 1 and 2, clarify requirements to reduce the risks associated with medical equipment, devices, and supplies.

In the last year, several significant issues have emerged related to cleaning, disinfecting, and sterilizing medical equipment, devices, and supplies (for example, the proper use of steam sterilization, as discussed in Perspectives, July 2009, page 8, and adequate high-level disinfection of endoscopes). Furthermore, medical technology and instrumentation is a rapidly changing field; new devices and new or resistant pathogens are emerging at an unprecedented pace.

There has been confusion in the field about the applicability of Standard IC.02.02.01. Because EP 1 refers to cleaning and disinfection, it applies to lower-risk processes. The current assignment of scoring category “C” reflects the level of potential impact on individuals served, patients, and residents.

EP 2 refers to sterilization and applies to higher-risk processes. EP 2 has been revised to show that, specifically, intermediate- and high-level disinfection are included with sterilization. The current assignment of scoring category “A” reflects the direct and serious potential impact on patients and residents.

Joint Commission surveyors will continue to survey for the following:

- Orientation, training, and competency of the health care workers who process medical equipment, devices, and supplies
- Levels of staffing and supervision of the health care workers who process medical equipment, devices, and supplies
- Standardization of the process regardless of whether it is centralized or decentralized
- Ongoing quality monitoring
- Observation against the manufacturer’s guidelines and the organization’s procedures

The revisions to IC.02.02.01 are shown in the box below and on pages 5 and 6 with additions in underlined text and deletions in strikethrough text.
workers who are processing medical equipment, devices, and supplies

- Levels of staffing and supervision of the health care workers who are processing medical equipment, devices, and supplies
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring

Applicable to Behavioral Health Care

Rationale for Standard IC.02.02.01

Individuals served are at risk of developing an infection from contact with medical supplies and devices. Failure to properly clean or disinfect, and use or store, medical supplies and devices not only poses risks for the individual seeking services, but also carries the risk for person-to-person spread of infections.

There are several steps involved in the cleaning and disinfecting of medical supplies and devices. It is critical that staff follow standardized practices to minimize infection risks related to medical supplies and devices. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:

- Orientation, training, and competency of health care workers who are processing medical supplies and devices
- Supervision of the health care workers who are processing medical supplies and devices
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring

Applicable to Laboratories

Rationale for Standard IC.02.02.01

People are at risk of developing an infection from contact with laboratory equipment, devices, or supplies. Failure to properly clean, disinfect, or sterilize, and use or store, laboratory equipment, devices, and supplies poses the risk for person-to-person transmission of infections.

There are numerous steps involved in the cleaning, disinfecting, and sterilizing of laboratory equipment, devices, and supplies. It is critical that health care workers follow standardized practices to minimize infection risks related to laboratory equipment, devices, and supplies. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:

- Orientation, training, and competency of health care workers who are processing laboratory equipment, devices, and supplies
- Levels of staffing and supervision of the health care workers who are processing laboratory equipment, devices, and supplies
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring

Applicable to Long Term Care

Rationale for Standard IC.02.02.01

Residents are at risk of developing an infection from contact with medical equipment, devices, or supplies while seeking health services. Failure to properly clean, disinfect, or sterilize, and use or store, medical equipment, devices, and supplies not only poses risks for the resident receiving health services, but also carries the risk for person-to-person spread of infections.

There are numerous steps involved in the cleaning, disinfecting, and sterilizing of laboratory equipment, devices, and supplies. It is critical that health care workers follow standardized practices to minimize infection risks related to medical equipment, devices, and supplies. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:

- Orientation, training, and competency of health care workers who are processing medical equipment, devices, and supplies
- Levels of staffing and supervision of the health care workers who are processing medical equipment, devices, and supplies
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring

Applicable to Home Care

Rationale for Standard IC.02.02.01

People are at risk of developing an infection from contact with medical equipment, devices, or supplies while seeking health services. Failure to properly clean or disinfect, and use or store, medical equipment, devices, and supplies not only poses risks for the person seeking health services, but also carries the risk for person-to-person spread of infections.

Continued on page 6
There are numerous steps involved in the cleaning and disinfecting of medical equipment, devices, and supplies. It is critical that health care workers follow standardized practices to minimize infection risks related to medical equipment, devices, and supplies. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:

- Orientation, training, and competency of health care workers who are processing medical equipment, devices, and supplies
- Levels of staffing and supervision of the health care workers who are processing medical equipment, devices, and supplies
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring

### Elements of Performance for Standard IC.02.02.01

#### Applicable to Ambulatory Care, Critical Access Hospitals, Home Health, Hospitals, Long Term Care, and Office-Based Surgery

1. The organization implements infection prevention and control activities when doing the following: Cleaning and disinfecting performing low-level disinfection of medical equipment, devices, and supplies.

#### Applicable to Ambulatory Care, Critical Access Hospitals, Home Health, Hospitals, Office-Based Surgery

**Note:** Low-level disinfection is used for items such as blood glucose meters. Additional cleaning and disinfecting is required for medical supplies and devices used by individuals who require the use of other precautions in addition to standard precautions. These “other precautions” are also known as “transmission-based” precautions.

Footnote: For further information regarding cleaning and performing low-level disinfection of medical supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/ncidod/dhdp/sterile.html (Sterilization and Disinfection in Healthcare Settings).

### Applicable to Laboratories

1. The laboratory implements infection prevention and control activities when doing the following: Cleaning and disinfecting performing low-level disinfection of laboratory equipment, devices, and supplies.

**Note:** Low-level disinfection is used for items such as blood glucose meters. Additional cleaning and disinfecting is required for laboratory equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.

Footnote: For further information regarding cleaning and performing low-level disinfection of medical supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/ncidod/dhdp/sterile.html (Sterilization and Disinfection in Healthcare Settings).

### Applicable to Ambulatory Care, Critical Access Hospitals, Hospitals, Laboratories, Long Term Care, and Office-Based Surgery

2. The organization implements infection prevention and control activities when doing the following: Sterilizing Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

**Note:** High-level disinfection is used for items such as respiratory equipment and specula. Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.

Footnote: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/ncidod/dhdp/sterile.html (Sterilization and Disinfection in Healthcare Settings).

### Applicable to Behavioral Health Care

1. The organization implements infection prevention and control activities when doing the following: Cleaning and disinfecting performing low-level disinfection of medical supplies and devices.
The Joint Commission’s Board of Commissioners approved an amendment to the 2009 Survey Fee Schedule, effective August 1, 2009, to include two survey events for which a fee structure did not previously exist. These two survey events are the Follow-up Survey related to a Condition-level deficiency and an Onsite Evidence of Standards Compliance (ESC).

The follow-up survey for Condition-level deficiency applies to hospitals, home care, hospices, critical access hospitals, and ambulatory surgery centers that use Joint Commission accreditation for Medicare deeming purposes. The new fee is set at the same level as Conditional Accreditation follow-up surveys and special surveys: $4,130 per surveyor day for the first day and $1,945 per surveyor for the second and subsequent day(s).

An Onsite ESC event is conducted in any accredited organization when Joint Commission leadership determines that standards compliance needs to be validated on site. In these cases, the organization submits an electronic ESC, and The Joint Commission schedules a survey to validate the information in it. The Onsite ESC survey fee is set at the same level as routine full survey rates, as shown in the table on the right.

For pricing questions, please contact the Joint Commission Pricing Unit at 630/792-5115 or pricingunit@jointcommission.org.

Inaccurate service applicability grids were included in the 2009 Update 1 for the Comprehensive Accreditation Manual for Home Care (CAMHC), which published in June. To provide accurate information to customers immediately, The Joint Commission posted all the 2009 home care standards, elements of performance, and corrected service applicability grids online at http://www.jointcommission.org/AccreditationPrograms/HomeCare/Standards/home_stds_aug_09.htm.

Please note that the inaccurate service applicability grids appeared only in the hard-copy Update 1 to the 2009 CAMHC. The Periodic Performance Review, E-dition, AMP (Accreditation Manager Plus), and surveyor laptops were not affected and have always contained accurate applicability information. The posted home care applicability grids are in effect through December 31, 2009.

Accurate applicability grids will be included in Update 2 for the 2009 CAMHC, which will publish in late October. We regret the error and any inconvenience it has caused.
Changes to Survey Activities for Deemed Status Ambulatory Surgical Centres

The Centers for Medicare & Medicaid Services (CMS) recently revised its survey procedures for ambulatory surgical centers (ASCs). **Effective October 1, 2009**, The Joint Commission will implement changes to the following survey activity sessions to align with CMS requirements:

- Surveyor Arrival & Preliminary Planning
- Orientation to the Organization
- Individual Tracer
- Competence Assessment
- Environment of Care/Equipment
- System Tracers

These changes apply to those ASCs that use Joint Commission accreditation for deemed status purposes.

The changes, summarized in the box below, will be included in the 2010 edition of the Survey Activity Guide (found online for accredited customers or initial applicants at http://www.jointcommission.org/AccreditationPrograms/AmbulatoryCare).

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**Effective October 1, 2009**  
**APPLICABLE TO DEEMED STATUS AMBULATORY SURGICAL CENTERS**

**Surveyor Arrival & Preliminary Planning Session**

Once the surveyor(s) arrives on site and staff has confirmed the validity of the survey and the identity of the surveyor(s) via its Joint Commission Connect extranet, the ASC will need to assemble specific documents for the surveyor(s) review during the on-site visit. Because surveys are unannounced, organizations may want to gather these resources ahead of time and keep them in a central location. A list of these documents can be found online in the Survey Activity Guide and on the ASC’s Joint Commission Connect extranet page. The following documents must also be made available for surveyors:

- Surgery schedules for each day of the survey
- A list of contracted services, if applicable
- List of surgeries from the past six months
- List of cases in the past 12 months, if any, where the patient was transferred to a hospital or that patient died *(Note: the 12-month time frame for this data applies to all ASCs, whether this is an initial or resurvey)*
- Governance or governing body meeting minutes
- Documentation of the most recent performance evaluation of contracted services, if applicable
- Documentation related to the allocation of resources (such as personnel, information systems, data management, and staff training) to support performance improvement activities
- Hospital transfer agreements, if applicable

**Orientation to the Organization**

Additional topics to be discussed and explored during this survey activity will include the following:

- The ASC governing body’s legal responsibility for determining, implementing, and monitoring policies that govern overall operations
- Operational management structure, including the delegation of responsibility for nursing services, the infection prevention and control program, and supervision of radiology services
- Infection prevention and control guidelines used by the ASC to develop and guide operational policies and procedures
- Hospital transfer process

**Individual Tracer**

Additional topics to be discussed and explored during this survey activity will include the following:

- Infection prevention and control procedures: Pre-surgical history and physicals; orders for care, treatment, and services; anesthesia recovery; and discharge, along with related documentation

*Continued on page 9*
A New Model for Customer Service at The Joint Commission

In September, The Joint Commission redesigned its Division of Accreditation and Certification Operations to allow account representatives to specialize in a specific accreditation program and to thereby provide superior customer service to Joint Commission–accredited and –certified organizations. With this redesign, the “account representative” title has changed to “account executive” to recognize the importance of the role.

The redesign will enhance customer support and services throughout the accreditation and certification process by establishing and retaining a primary point of contact for the accredited organization or certified program. To provide more comprehensive support to each organization, the primary account executives are now teamed with program-specific standards interpretation professionals and field directors. This will improve the timeliness and thoroughness of responses to questions about the accreditation process. (Note: Questions about standards and National Patient Safety Goals should still be made through the online submission form found at http://www.jointcommission.org/Standards/OnlineQuestionForm or by calling 630/792-5900, option 6.)

How Does This Affect Your Organization?

The Joint Commission has reassigned some account executives to different organizations. Depending on the complexity of your organization, you could have additional supporting account executives assigned for laboratory accreditation or for disease-specific care or health care staffing services certification to provide expert knowledge for those unique programs.

If your organization is accredited or certified, The Joint Commission informed you of your new account executive’s name and contact information in September. This information can also be found on the landing page of your Joint Commission ConnectTM site. If you have any questions or concerns about the transition, please contact your new account executive at his or her direct extension.

Changes to Survey Activities for Deemed Status Ambulatory Surgical Centers (continued)

Survey Activity Changes for Deemed ASCs (continued)

- The process(es) the ASC uses to provide patients with information on patient rights, financial interest disclosure, and advance directives (surveyors may ask to see, for example, brochures and other printed matter or e-mail messages used to notify patients in advance of the procedure of their rights)
- Staff and patient awareness of the ASC’s complaint and grievance resolution process
- Radiation hazards prevention and safety measures for staff and patients
- Infection prevention and control, which may involve the completion an infection control worksheet to evaluate and document compliance with CMS requirements

Competence Assessment

This survey activity will include a more comprehensive and detailed personnel file review to assess the ASC’s compliance with its policies for evaluating staff qualifications and competencies and granting privileges to licensed independent practitioners.

Environment of Care Session, Equipment, and Emergency Management Session

Additional topics to be discussed and explored during this survey activity will include the following:

- The ASC’s emergency management plan* and how potential emergencies are identified
- How the emergency management plan coordinates with the ASC’s community, county, or regional emergency management program
- Emergency management drills and critiques and related documentation

System Tracers

Additional topics will be discussed and explored during Data Management and Infection Control System Tracers specific to ASCs seeking deemed status for components required by Medicare.

* ASCs are required to have a written emergency management plan, even if they plan only to shut down services and close during an emergency.
Safety should be rooted in the culture and the system of a health care organization. A new Joint Commission Sentinel Event Alert issued in August urges health care leaders to increase efforts to prevent errors by taking the zero-defect approach used in other high-risk industries such as aviation and nuclear energy. The Joint Commission advocates greater involvement of health care trustees, executives, and physician leaders, contending that the overall safety and effectiveness of a health care facility depends on administrative and clinical leaders who set the tone, create the culture, and drive improvements.

“Health care leaders are directly responsible for establishing a culture of safety,” says Mark R. Chassin, M.D., M.P.P., M.P.H., president, The Joint Commission. “This Alert provides leaders with concrete strategies for demonstrating a commitment to safety and to improving patient outcomes.”

To improve patient safety, The Joint Commission’s Sentinel Event Alert recommends that the governing body, chief executive officer, senior managers, and medical staff leaders take a series of 14 specific steps, including the following:

- Define and establish an organizationwide safety culture that includes a code of conduct for all employees.
- Institute an organizationwide policy of transparency that sheds light on all adverse events and patient safety issues.
- Make the organization’s overall safety performance a key, measurable part of the evaluation of the CEO and all leadership.
- Ensure that caregivers involved in adverse events that result in unintentional patient harm receive attention that is just, respectful, compassionate, supportive, and timely.
- Create and communicate a policy that defines behaviors that are to be referred for disciplinary action and a time frame for that action to take place.
- Regularly monitor and analyze adverse events and close calls quantitatively and communicate findings and recommendations to leadership, the board and staff.
- Regularly hold open discussions to develop a true, unvarnished view of the safety risks and barriers to safety facing patients and staff.
- Make a visible commitment of time and money to improve the systems and processes needed to defend against hazards and minimize unsafe acts.
- Establish partnerships with physicians and align their incentives to improving safety and using evidence-based medicine.
- Add a human element to safety improvement by having patients communicate their experiences and perceptions to leadership.
- When planning and implementing safety improvements, use the expertise of front-line staff who understand the risks to patients and how processes really work.
- Regularly measure leadership’s commitment to safety using climate surveys and upward appraisal techniques (in which staff review or appraise their managers and leaders).
- Ask managers about the safety issues they encounter, how they were handled, and the impact their actions had on reducing unsafe conditions.
- Reward and recognize staff whose efforts contribute to safety.

In addition to specific recommendations contained in the Alert, The Joint Commission urges health care organizations to use its Leadership standards to improve patient safety, which require organization leaders to create a culture of safety and to provide the resources necessary for patient safety. The standards also cover reporting systems for adverse events and near misses and the design of processes to support safety.

The Joint Commission revised the Alert shortly after its release. The original August 27 release stated (under the section “Appropriate evaluation of adverse events and discipline”) that “large errors are considered for disciplinary action.” After additional consideration, that language now has been clarified with discussion of separating blameless acts and those blameworthy acts that require disciplinary action.

The emphasis on leadership in promoting greater patient safety is the most recent of a series of Alerts issued by The Joint Commission. Much of the information and guidance in these Alerts is drawn from the Joint Commission’s Sentinel Event Database, one of the nation’s most comprehensive voluntary reporting systems for serious adverse events in health care. The database includes detailed information about both adverse events and their underlying causes.

Sentinel Event Alert Issue 43 can be found on The Joint Commission Web site at http://www.jointcommission.org/SentinelEvents/SentinelEventAlert, along with previously released Alerts.
Dear Colleague,

The Medicare Improvements for Patients and Providers Act of 2008 requires all accrediting bodies to complete a formal application process so that their accredited hospitals will be recognized for Medicare “deemed status.” Since August 2008, The Joint Commission has been working with the Centers for Medicare & Medicaid Services (CMS) to understand its expectations for continuing our hospital deeming authority. In February 2009, The Joint Commission submitted its application for renewing our hospital deeming authority to CMS.

As part of CMS’ traditional deeming application review process, Joint Commission staff developed a crosswalk between the Medicare Hospital Conditions of Participation (COPs) and The Joint Commission hospital standards; developed computer-based technology to help our surveyors determine the manner and degree of noncompliance with the COPs; and participated in CMS’ evaluation of our survey processes, surveyor training programs, and Joint Commission Central Office policies and procedures. Any identified issues have been resolved as part of this review.

On March 26, 2009, The Joint Commission provided the field with changes in its standards and elements of performance that more closely align our requirements with those of CMS to the degree of specificity requested by CMS. Effective July 1, 2009, we implemented those changes in the Joint Commission's survey process and information systems.

This issue of Joint Commission Perspectives includes a special section that summarizes the changes in the relevant requirements, survey process, and policies or procedures that have been completed as part of the deeming application review process since March 2009. While the majority of these changes are effective immediately, several changes will be effective July 15, 2010, as noted in the following articles.

We appreciate that this has been a year of significant change for our hospital customers as we incorporated specific CMS COPs into the Joint Commission standards. We thank you for your patience with the frequent updates. We know that it is very important to communicate these changes promptly and answer any questions our customers may have. Please feel free to contact us if we can be of any assistance.

Sincerely,

Ann Scott Blouin, Ph.D., R.N.
Executive Vice President, Accreditation and Certification Operations
The Joint Commission
Effective July 1, 2009, for organizations that use Joint Commission accreditation for deemed status purposes, The Joint Commission modified the Accreditation Survey Findings Report to include both Joint Commission and Medicare requirements identified as being less than fully compliant at the time of survey. Crosswalks of the Joint Commission’s requirements to Medicare Conditions of Participation (COPs) have been developed and are easily viewed in the new report format.

The accreditation decision report now includes a “Summary of CMS Findings” section, as shown in the example in Figure 1 on page 13. This summary provides, at a glance, crosswalks of noncompliant Medicare requirements to corresponding Joint Commission standards and elements of performance (EPs) that were found less than fully compliant. The report also identifies the deficiency level for each non-compliant Medicare requirement (Condition or Standard).

The “Joint Commission Findings” section of the report (shown in the example in Figure 2 on page 13) now includes the Medicare Condition and Standard numbers, tags, and text for the CMS requirements that crosswalk to the Joint Commission EPs that are identified as being less than fully compliant.

For all surveyed organizations, including those not using Joint Commission accreditation for deemed status purposes, the “Joint Commission Findings” section of the Accreditation Survey Findings Report has also been modified to include the level of criticality (Situational Decision Rules – 2; Direct Impact – 3; Indirect Impact – 4) for all EPs identified as partially compliant or insufficiently compliant. In addition, Joint Commission EPs which were initially identified as less-than-fully compliant but were corrected before the conclusion of the survey are now designated as Observed but Corrected on Site (OCO).

**Faster Posting of Final Report**

Since July 2009, The Joint Commission has been posting the Accreditation Survey Findings Report to all surveyed organizations’ secure extranet site on Joint Commission ConnectTM within 10 business days of completing a survey. Through the use of Lean Six Sigma and Robust Process ImprovementTM tools, The Joint Commission identified several improvements to the early post-survey process which enables the survey report to be posted in a timely manner. This improvement also aligns with a CMS requirement to post survey reports during that time frame for organizations participating in the deemed status survey option. Once the survey report is posted, the organization has 10 business days to begin Evidence of Standards Compliance (ESC) clarification process. Organizations still have 45 and/or 60 days to submit their corrective ESC responses.

**Clarification: Conducting Extension Surveys**

The Joint Commission conducts an extension survey when an accredited organization acquires a new service, program, or site for which The Joint Commission has standards. Extension surveys are done to ensure that the accreditation decision previously awarded to the organization is still appropriate under changed conditions.

Effective immediately, if an organization uses Joint Commission accreditation for deemed status purposes, an extension survey will be conducted within six months of the acquisition of a new service, program, or site. In addition, the results of the extension survey for these organizations will immediately affect the accreditation status of the acquiring organization. This clarifies the article “Approved: An Extension for Extension Surveys,” published in the May 2009 issue of Perspectives (page 8), which applies to organizations that do not use Joint Commission accreditation for deemed status purposes.
Figure 1. Example Summary of CMS Findings

Report – Summary of CMS Findings

The Joint Commission
Summary of CMS Findings

CoP: §482.12  Tag: A-0043  Deficiency: Condition
Corresponds to: HAP
Text: §482.12 Condition of Participation: Governing Body

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

<table>
<thead>
<tr>
<th>CoP Standard</th>
<th>Tag</th>
<th>Corresponds to</th>
<th>Deficiency</th>
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<td>§482.12(a)</td>
<td>A-0051</td>
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CoP: §482.22  Tag: A-0358  Deficiency: Standard
Corresponds to: HAP
Text: §482.22 Condition of Participation: Medical Staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

<table>
<thead>
<tr>
<th>CoP Standard</th>
<th>Tag</th>
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<th>Deficiency</th>
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Figure 2. Example Joint Commission Findings

Report – Findings

Chapter: Human Resources
Program: Hospital Accreditation
Standard: HR.01.02.01

Standard Text: The hospital defines staff qualifications.

Primary Priority Focus Area: Staffing

Element(s) of Performance:
1. The hospital defines staff qualifications specific to their job responsibilities. (See edge: 01.01.01, EP-7)
   Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).
   Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88) under Subpart M. Personnel for "Narrowed Testing" 493.151/493.149. A complete description of the requirement is located at http://www.cdc.gov/CLIA/.

Scoring Category: Score: Insufficient Compliance

Observation(s):
EP 1 §482.75(b) (A-1130) §482.75(b) Standard: Delivery of Services

Services must be given in accordance with orders of practitioners who are authorized by the medical staff to render the services, and the orders must be incorporated in the patient’s record. The provision of care and the personnel qualifications must be in accordance with rational acceptable standards of practice and must also meet the requirements of §493.17.

This Standard is NOT MET as evidenced by:
Observation in tracing at Survey Technology Institute site.
Document noting...
Hospital Accreditation Award Aligned with CMS Certification Number

As reported in the September 2009 issue of Perspectives (page 3), The Joint Commission is aligning its accreditation awards with the Centers for Medicare & Medicaid Services (CMS) Certification Numbers (CCNs) for accredited hospitals seeking deemed status. This policy has been in place since 2008 for new Joint Commission hospital applicants. CMS assigns a CCN to a hospital or group of hospitals based on the definition of hospital in subsection (e) of section 1861(42 U.S.C.1395x) of the Social Security Act. The vast majority of currently Joint Commission-accredited hospitals are accredited in accordance with their CCNs; therefore, there will not be any change to the way they have been accredited, including those of the Departments of Defense and Veterans Affairs. For approximately 300 hospitals that have not been accredited in accordance with their CCNs, The Joint Commission will be contacting each affected hospital on a one-to-one basis to discuss how to realign their accreditation award in accordance with their CCN by the effective date of July 15, 2010.

Historically, the CCN (formerly called a Medicare Provider Number) of a hospital or group of hospitals did not factor into determining eligibility for Joint Commission accreditation. In most cases, a hospital accreditation award for a single organization could be composed of two or more hospitals (“a system”), each with a separate CCN or sharing a single CCN. Less commonly, a hospital with a single CCN could be composed of multiple organizations, each currently surveyed and accredited as a separate organization by The Joint Commission. CCN numbers are awarded based on whether the entities have one integrated medical staff and governing body or whether entities operate independently of each other.

For the affected hospitals that are part of a system, the individual hospitals’ surveys could be conducted concurrently after the survey of shared functions, or each hospital survey could be conducted independently of each other.

Revision to the ESC Tool on Secure Extranet

After an accreditation survey report is posted to an organization’s secure extranet site, Joint Commission Connect™, the organization must submit Evidence of Standards Compliance (ESC) to demonstrate how it has corrected the issue(s) identified during the on-site survey as a Requirement(s) for Improvement. A change has been made as to how all accredited organizations should complete the online ESC tool.

Effective immediately, in the first section of the ESC, titled “WHO,” the organization must now indicate the title of the person who is responsible for implementing the corrective action. If the organization indicates a committee, it must also list the title of the accountable person on the committee. For example, if the organization identifies the “Performance Improvement Committee,” it must indicate the title of who on that committee is ultimately responsible, such as “Chair, Performance Improvement Committee.”

In addition, if the organization indicates the development or revision of a policy, procedure, or process is the corrective action, the organization must identify in the WHO section on the ESC the title of the person who has approved the policy, procedure, or process along with the title(s) of those trained to use the new action.

Please contact your account executive if you have any questions while completing your ESC.
For hospitals that use Joint Commission accreditation for deemed status purposes, The Joint Commission will now issue a Medicare recommendation letter in addition to the official accreditation award letter. The Joint Commission uses the Medicare recommendation letter to inform CMS that a new or existing Medicare provider has participated in a deemed status survey and that The Joint Commission is making a recommendation regarding Medicare certification as a result. The letter includes information on the dates of the survey, the outcome of the survey, the effective date of accreditation, and the locations included in the scope of the accreditation survey.

The Joint Commission provides a copy of the letter to the CMS central office and appropriate regional office. The regional office then makes the final determination regarding the Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. A sample of the Medicare recommendation letter is provided in the figure below.

---

### Figure. Sample Medicare Certification Recommendation Letter

September 17, 2009

Jane Doe  
CEO  
Community Hospital  
123 Main Street  
Anywhere, USA 12345

Dear Ms. Doe:

This letter confirms that your June 21-23, 2009 announced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission’s deemed status survey process.

Based upon the submission of your evidence of standards compliance on July 21 and August 4, 2009, the area of deficiency listed below has been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of June 24, 2009.

The Joint Commission is also recommending your organization for Medicare certification. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

CFR 482.26b Safety for Patients and Personnel

We congratulate you on your effective resolution of this standard-level deficiency.

This recommendation also applies to the following location(s):
- 123 Main Street, Anywhere, USA 12345
- 456 Broadway, Anywhere, USA 45678

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission’s agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Ann Scott Blosin, RN, Ph.D.  
Executive Vice President  
Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services  
CMS/Regional Office V/Survey and Certification Staff
The Centers for Medicare & Medicaid Services (CMS) required The Joint Commission to add specificity to its standards as a way to demonstrate equivalency with the Medicare hospital requirements. To accomplish this, The Joint Commission created new elements of performance (EPs) and revised others, publishing its first draft of those changes online in January 2009 (see February 2009 Perspectives, p. 3). The Joint Commission communicated an updated version of the changes in a second Web posting in March 2009 and via Perspectives (see April 2009 Perspectives, p. 6). The changes, implemented in July 2009, significantly reduced the original number of new or revised EPs.

CMS has continued to conduct its technical standards review as part of the deeming application process since that time. During this review, we have made additional minor revisions to EPs and created some new EPs that will clarify or meet the specificity of some Medicare requirements. The majority of revisions are minor editorial changes that include adding notes to standards and EPs to further clarify the intent of requirements. More substantive changes are shown in the box below and on page 17. The full text of all changes, including minor editorial revisions, will be available on The Joint Commission Web site at http://www.jointcommission.org/AccreditationPrograms/Hospitals.

Credentialing and Privileging by Proxy and Telemedicine

While revisions to telemedicine standards (shown in the box on pages 18 and 19) have been made at this time, The Joint Commission continues to engage CMS and members of Congress regarding the issue of credentialing and privileging by proxy as it relates to telemedicine providers and users. The Joint Commission believes that there would be an adverse effect on the access to some telehealth services if organizations are not allowed to comply with the current Joint Commission requirements addressing credentialing and privileging by proxy. Further, the CMS requirements will likely place an undue burden on many organizations without improving the quality of services and the effectiveness of the credentialing and privileging processes or their accountability.

There is no final agreement or change to federal regulation at this time; therefore, The Joint Commission must survey to the current Medicare requirements regarding credentialing and privileging. The revisions have been made to facilitate this change and will be implemented July 15, 2010.

For more information on credentialing and privileging by proxy, see the introduction to Standard MS.13.01.01 titled “Telemedicine” in the Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH).

**ACCEPTED:** New and Revised Hospital Elements of Performance Related to CMS Application Process

**Requirements Effective January 1, 2010 and July 15, 2010**

The Centers for Medicare & Medicaid Services (CMS) required The Joint Commission to add specificity to its standards as a way to demonstrate equivalency with the Medicare hospital requirements. To accomplish this, The Joint Commission created new elements of performance (EPs) and revised others, publishing its first draft of those changes online in January 2009 (see February 2009 Perspectives, p. 3). The Joint Commission communicated an updated version of the changes in a second Web posting in March 2009 and via Perspectives (see April 2009 Perspectives, p. 6). The changes, implemented in July 2009, significantly reduced the original number of new or revised EPs.

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**Official Publication of Joint Commission Requirements**

**Revised Hospital Requirements**

**APPLICABLE TO HOSPITALS SEEKING DEEMED STATUS**

**Effective January 1, 2010**

**or July 15, 2010 as noted**

**New Elements of Performance for Implementation January 1, 2010**

**EC.02.04.03, EP 14**—For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented.

**HR.01.01.01, EP 28**—For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting pharmacist develops, supervises, and coordinates all the activities of the pharmacy department or pharmacy services.

**LD.04.01.05, EP 9**—For hospitals that use Joint Commission accreditation for deemed status purposes: The anesthesia service is responsible for all anesthesia administered in the hospital.

*Continued on page 18*
Revised Hospital Requirements (continued)

MS.03.01.01, EP 16—For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.

MS.03.01.01, EP 17—For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director’s specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

PC.03.01.01, EP 10—For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital’s policy and state scope of practice laws, anesthesia is administered only by the following individuals:

- An anesthesiologist
- A doctor of medicine or osteopathy other than an anesthesiologist
- A doctor of dental surgery or dental medicine
- A doctor of podiatric medicine
- A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision
- An anesthesiologist’s assistant supervised by an anesthesiologist
- A supervised trainee in an approved educational program

Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission.

Note 2: “Anesthesiologist assistant” is defined in 42 CFR 410.69(b).

Footnote: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state’s Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that he or she has consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state’s citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.

RI.01.07.01, EP 18—For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of complaints, the hospital provides the individual with a written notice of its decision, which contains the following:
- The name of the hospital contact person
- The steps taken on behalf of the individual to investigate the complaint
- The results of the process
- The date of completion of the complaint process

Revised Elements of Performance for Implementation January 1, 2010

LD.04.04.05, EP 13—At least once a year, the hospital provides governance with written reports on the following:
- All system or process failures
- The number and type of sentinel events
- Whether the patients and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences
- For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually

PI.01.01.01, EP 2—The leaders identify the frequency for data collection.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders that specify the frequency and detail of data collection is the governing body.

New Element of Performance for Implementation July 15, 2010

LD.01.05.01, EP 8—For hospitals that use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff.
LD.04.03.09, EP 4—Leaders monitor contracted services by establishing expectations for the performance of the contracted services.

**Note 1:** For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:

- Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.

**Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site. (See also MS.13.01.01, EP 1 and LD.04.03.09, EP 4)

**MS.13.01.01, EP 1**—For hospitals that use Joint Commission accreditation for deemed status purposes: All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site, according to standards MS.06.01.03 through MS.06.01.13.

**Note:** If the distant site is a Medicare-participating hospital, the originating site’s medical staff may use a copy of the distant site’s credentialing packet for privileging purposes. This packet includes a list of all privileges granted to the licensed independent practitioner by the distant site and an attestation signed by the distant site indicating that the packet is complete, accurate, and up to date.

**For hospitals that do not use Joint Commission accreditation for deemed status purposes:** All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:

- The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.
- The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization.
- The originating site uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
  1. The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
  2. The practitioner is privileged at the distant site for those services to be provided at the originating site.
Organizations undergoing their initial Joint Commission survey* must have a sufficient number of inpatient records for review to adequately determine compliance with accreditation requirements. This can include both closed records from discharged patients and open records for current inpatients at the time of survey. **Effective immediately, for general acute care hospitals that use Joint Commission accreditation for deemed status purposes** to be eligible for an initial survey, the number of records must equal 10% of the average daily census but not fewer than 30 inpatient records. For small general hospitals with an average daily census of 20 patients or fewer, the sample should not be fewer than 20 inpatient records, provided the number of records is adequate to determine compliance. This does not apply to surgical or other specialty hospitals. There is no change to the requirement that at least one inpatient must be in active treatment during the survey.

**Medical Record Review During Medicare Certification Surveys**

Currently, during a Medicare certification survey, Joint Commission surveyors will review this same number of medical records, that is, 10% of the ADC or a minimum of 30 inpatient records or 20 for small general acute care hospitals (but not for surgical or other specialty hospitals). This requirement is normally met through individual patient tracers and system tracers such as Infection Control and Medication Management. This survey process will not change, but hospitals seeking deemed status should be aware that surveyors may ask to review additional open and closed records while surveying a particular issue if they have not met this minimum number of records reviewed during tracers.

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**Accepted: New and Revised Hospital EPs Related to CMS Application Process (continued)**

Continued from page 18

### Revised Hospital Requirements for Telemedicine (continued)

3. The originating site has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (See also LD.04.03.09, EP 9)

**Note 1:** This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

**Note 2:** In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care.

**Note 3:** A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. See the Sentinel Events (SE) chapter for additional information.
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.

Changes to the 2010 National Patient Safety Goals

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

<table>
<thead>
<tr>
<th>NPSG Description</th>
<th>NPSG</th>
<th>Program Applicability and Disposition</th>
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<tr>
<td>Two patient identifiers</td>
<td>NPSG Delete EP 1</td>
<td>AHC/OBS: Delete EP 1</td>
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<tr>
<td>Time-out</td>
<td>NPSG Delete EP 1</td>
<td>BHC: Delete EP 1</td>
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<td>Transfusion patient identification</td>
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<td>OME: Delete EP 1</td>
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<td>HAP/CAH: Move to PC.02.01.03, EP 20</td>
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<td>Label meds</td>
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### Changes to the 2010 National Patient Safety Goals (continued)

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<th>Program Applicability and Disposition</th>
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<td>Preventing home fires</td>
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<td>Universal Protocol ‡</td>
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<td>NPSG</td>
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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. [AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME]

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: Note: 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: Note: 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: Note: 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: Note: An 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] © [LAB: Collaborate with organization leaders to develop] [CAH, HAP: Develop] written procedures for managing the critical results of tests and diagnostic procedures that address the following:
- 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.

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

Rationale for NPSG.03.04.01 [AHC, CAH, HAP, OBS]
Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of safe medication management, yet it is routine in many organizations. The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09.

Elements of Performance for NPSG.03.04.01
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.
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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 thromboembolism 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), low molecular weight heparin, and warfarin.

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 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.

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

Rationale for NPSG.07.03.01 [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).

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)

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. 

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.

A 4. [CAH, HAP] Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.

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

Note: Surveillance may be targeted rather than [organization]-wide.

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.

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
Provide central line–associated bloodstream infections.

Conduct periodic risk assessments for surgical site infections.

Perform hand hygiene prior to catheter insertion.

Use a standardized protocol for sterile barriers during central venous catheter insertion.

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 control.

C 8. [CAH, HAP] For adult patients, 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 barriers during central venous catheter insertion.

C 11. [CAH, HAP] Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients 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 these procedures is added to an individual’s job responsibilities.

C 2. [CAH, HAP] Prior to insertion of a central venous catheter, educate patients 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 patients, do not insert catheters into the femoral vein unless other sites are unavailable.

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 patients 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 patients 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 patients, 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 barriers during central venous catheter insertion.

C 11. [CAH, HAP] Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients 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.
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, BHC, 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 hand-overs.

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
C 1. [LTC, LT2, OME] Assess the patient’s risk for falls.
A 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.

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.

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.

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
C 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 10: The [organization] identifies safety risks inherent in its [patient] population. [BHC, HAP, OME]

NPSG.10.01.01 [BHC, HAP]
Identify [patient]s at risk for suicide.

Rationale for NPSG.10.01.01 [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.10.01.01
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.

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

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

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-
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.
According to the World Health Organization, only about 50% of U.S. medical patients take their medication as prescribed. Studies also show that anywhere from 20% to 80% of patients in developed countries either do not follow their prescriptions or take their medications at all. *Patient-Focused Medication Management* looks at the medication management process—with a focus on the patient—and emphasizes why involving patients and their families in medication management efforts is crucial in all health care settings. This book gives health care providers information they need to engage patients in their care and ensure that their patients safely and completely adhere to their medication regimens. Features include the following:

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- Practical tips on how to teach patients about their medications and build rapport with them through improved communication
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