National Patient Safety Goal Self-Assessment

National Patient Safety Goal 1: Improve the accuracy of patient identification.

NPSG.01.01.01: Use at least two patient identifiers when providing care, treatment, and services.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier.	AHC, BHC, CAH, OME, HAP, LAB, NCC, OBS			
2	Label containers used for blood and other specimens in the presence of the patient.	AHC, BHC, CAH, OME, HAP, LAB, NCC, OBS			

NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Before initiating a blood or blood component transfusion: ■ Match the blood or blood component to the order. ■ Match the patient to the blood or blood component. ■ Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding.	AHC, CAH, HAP, OBS			
2	When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient.	AHC, CAH, HAP, OBS			
3	When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process as determined by the organization.	AHC, CAH, HAP, OBS			

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National Patient Safety Goal 2: Improve the effectiveness of communication among caregivers.

NPSG.02.03.01: Report critical results of tests and diagnostic procedures on a timely basis.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	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	CAH, HAP, LAB			
2	Implement the procedures for managing the critical results of tests and diagnostic procedures.	CAH, HAP, LAB			
3	Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.	CAH, HAP, LAB			

National Patient Safety Goal 3: Improve the safety of using medications

NPSG.03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.	AHC, CAH, HAP, OBS			
2	In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.	AHC, CAH, HAP, OBS			
3	In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: ■ Medication or solution name ■ Strength ■ Amount of medication or solution containing medication (if not apparent from the container) ■ Diluent name and volume (if not apparent from the container) ■ Expiration date when not used within 24 hours ■ Expiration time when expiration occurs in less than 24 hours	AHC, CAH, HAP, OBS			
4	Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.	AHC, CAH, HAP, OBS			

(continued on page 14)

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5	Label each medication or solution as soon as it is prepared, unless it is immediately administered.	AHC, CAH, HAP, OBS			
6	Immediately discard any medication or solution found unlabeled.	AHC, CAH, HAP, OBS			
7	Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.	AHC, CAH, HAP, OBS			
8	All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.	AHC, CAH, HAP, OBS			

NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.	AHC, CAH, HAP, NCC			
2	Use approved protocols for the initiation and maintenance of anticoagulant therapy.	AHC, CAH, HAP, NCC			
3	Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.	AHC, CAH, HAP, NCC			
4	Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.	AHC, CAH, HAP, NCC			
5	When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.	AHC, CAH, HAP, NCC			
6	A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.	AHC, CAH, HAP, NCC			
7	Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following: ■ The importance of follow-up monitoring ■ Compliance ■ Drug-food interactions ■ The potential for adverse drug reactions and interactions	AHC, CAH, HAP, NCC			
8	Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.	AHC, CAH, HAP, NCC			

(continued on page 17 in the electronic version of this newsletter)

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NPSG.03.06.01: Maintain and communicate accurate patient medication information.					
EP	**Requirement**	**Applies to:**	**In compliance?**	**Actions Taken**	**Results of Actions Taken**
1	Obtain information on the medications the patient is currently taking when he or she is admitted to the organization or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.	AHC, BHC, CAH, HAP, OME, NCC, OBS			
2	Define the types of medication information to be collected in non–24-hour settings and different patient circumstances.	AHC, BHC, CAH, HAP, OME, NCC, OBS			
3	Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies.	AHC, BHC, CAH, HAP, OME, NCC, OBS			
4	Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).	AHC, BHC, CAH, HAP, OME, NCC, OBS			
5	Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.	AHC, BHC, CAH, HAP, OME, NCC, OBS			

National Patient Safety Goal 6: Reduce the harm associated with clinical alarm systems.

NPSG.06.01.01: Improve the safety of clinical alarm systems.					
EP	**Requirement**	**Applies to:**	**In compliance?**	**Actions Taken**	**Results of Actions Taken**
1	Leaders establish alarm system safety as a hospital priority.	CAH, HAP			
2	Identify the most important alarm signals to manage based on the following: ■ Input from the medical staff and clinical departments ■ Risk to patients if the alarm signal is not attended to or if it malfunctions ■ Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue ■ Potential for patient harm based on internal incident history ■ Published best practices and guidelines	CAH, HAP			

(continued on page 18)

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3	As of January 1, 2016, establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: ■ Clinically appropriate settings for alarm signals ■ When alarm signals can be disabled ■ When alarm parameters can be changed ■ Who in the organization has the authority to set alarm parameters ■ Who in the organization has the authority to change alarm parameters ■ Who in the organization has the authority to set alarm parameters to "off" ■ Monitoring and responding to alarm signals ■ Checking individual alarm signals for accurate settings, proper operation, and detectability	CAH, HAP			
4	As of January 1, 2016, educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.	CAH, HAP			

National Patient Safety Goal 7: Reduce the risk of health care–associated infections.

NPSG.07.01.01: Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines.	AHC, BHC, CAH, HAP, LAB, NCC, OBS, OME			
2	Set goals for improving compliance with hand hygiene guidelines.	AHC, BHC, CAH, OME, HAP, LAB, NCC, OBS			
3	Improve compliance with hand hygiene guidelines based on established goals.	AHC, BHC, CAH, HAP, LAB, NCC, OBS, OME			

NPSG.07.03.01: Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission.	CAH, HAP			

(continued on page 19)

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2	Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.	CAH, HAP			
3	Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection. prevention strategies	CAH, HAP			
4	Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.	CAH, HAP			
5	Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following: ■ Multidrug-resistant organism infection rates using evidence-based metrics ■ Compliance with evidence-based guidelines or best practices ■ Evaluation of the education program provided to staff and licensed independent practitioners	CAH, HAP			
6	Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.	CAH, HAP			
7	Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).	CAH, HAP			
8	When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.	CAH, HAP			
9	When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.	CAH, HAP			

NPSG.07.04.01: Implement evidence-based practices to prevent central line–associated bloodstream infections.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual's job responsibilities.	CAH, HAP, NCC			

(continued on page 20)

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2	Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention.	CAH, HAP, NCC			
3	Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).	CAH, HAP, NCC			
4	Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the organization, and this infection surveillance activity is organizationwide, not targeted.	CAH, HAP, NCC			
5	Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.	CAH, HAP, NCC			
6	Use a catheter checklist and a standardized protocol for central venous catheter insertion.	CAH, HAP, NCC			
7	Perform hand hygiene prior to catheter insertion or manipulation.	CAH, HAP, NCC			
8	For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.	CAH, HAP, NCC			
9	Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.	CAH, HAP, NCC			
10	Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.	CAH, HAP, NCC			
11	Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations.	CAH, HAP, NCC			
12	Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.	CAH, HAP, NCC			
13	Evaluate all central venous catheters routinely and remove nonessential catheters.	CAH, HAP, NCC			

(continued on page 21)

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NPSG.07.05.01: Implement evidence-based practices for preventing surgical site infections.					
EP	**Requirement**	**Applies to:**	**In compliance?**	**Actions Taken**	**Results of Actions Taken**
1	Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual's job responsibilities.	AHC, CAH, HAP, OBS			
2	Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.	AHC, CAH, HAP, OBS			
3	Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).	AHC, CAH, HAP, OBS			
4	As part of the effort to reduce surgical site infections: ■ Conduct periodic risk assessments for surgical site infections in a time frame determined by the organization. ■ Select surgical site infection measures using best practices or evidence-based guidelines. ■ Monitor compliance with best practices or evidence-based guidelines. ■ Evaluate the effectiveness of prevention efforts.	AHC, CAH, HAP, OBS			
5	Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The organization's measurement strategies follow evidence-based guidelines.	AHC, CAH, HAP, OBS			
6	Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.	AHC, CAH, HAP, OBS			
7	Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.	AHC, CAH, HAP, OBS			
8	When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.	AHC, CAH, HAP, OBS			

(continued on page 22)

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NPSG.07.06.01: Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Insert indwelling urinary catheters according to established evidence-based guidelines that address the following: ■ Limiting use and duration to situations necessary for patient care ■ Using aseptic techniques for site preparation, equipment, and supplies	CAH, HAP			
2	Manage indwelling urinary catheters according to established evidence-based guidelines that address the following: ■ Securing catheters for unobstructed urine flow and drainage ■ Maintaining the sterility of the urine collection system ■ Replacing the urine collection system when required ■ Collecting urine samples	CAH, HAP			
3	Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following: ■ Selecting measures using evidence-based guidelines or best practices ■ Monitoring compliance with evidence-based guidelines or best practices ■ Evaluating the effectiveness of prevention efforts	CAH, HAP			

National Patient Safety Goal 9: Reduce the risk of patient harm resulting from falls.

NPSG.09.02.01: Reduce the risk of falls.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Assess the patient's risk for falls.	NCC, OME			
2	Implement interventions to reduce falls based on the patient's assessed risk.	NCC, OME			
3	Educate staff on the fall reduction program in time frames determined by the organization.	NCC, OME			
4	Educate the patient and, as needed, the family on any individualized fall reduction strategies.	NCC, OME			
5	Evaluate the effectiveness of all fall reduction activities, including assessment, interventions, and education.	NCC, OME			

(continued on page 23)

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National Patient Safety Goal 14: Prevent health care–associated pressure ulcers (decubitus ulcers).

NPSG.14.01.01: Assess and periodically reassess each patient's and resident's risk for developing a pressure ulcer and take action to address any identified risks.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Create a written plan for the identification of risk for and prevention of pressure ulcers.	NCC			
2	Perform an initial assessment at admission to identify patients and residents at risk for pressure ulcers.	NCC			
3	Conduct a systematic risk assessment for pressure ulcers using a validated risk assessment tool such as the Braden Scale or Norton Scale.	NCC			
4	Reassess pressure ulcer risk at intervals defined by the organization.	NCC			
5	Take action to address any identified risks to the patient or resident for pressure ulcers, including the following: ■ Preventing injury to patients and residents by maintaining and improving tissue tolerance to pressure in order to prevent injury ■ Protecting against the adverse effects of external mechanical forces	NCC			
6	Educate staff on how to identify risk for and prevent pressure ulcers.	NCC			

National Patient Safety Goal 15: The organization identifies safety risks inherent in its patient population.

NPSG.15.01.01: Identify patients at risk for suicide.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.	BHC, HAP			
2	Address the patient's immediate safety needs and most appropriate setting for treatment.	BHC, HAP			
3	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.	BHC, HAP			

(continued on page 24)

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NPSG.15.02.01: Identify risks associated with home oxygen therapy such as home fires.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: ■ Whether there are smoking materials in the home ■ Whether or not the home has functioning smoke detectors ■ Whether there are other fire safety risks in the home, such as the potential for open flames Document the performance of the risk assessment.	OME			
2	Reevaluate potential fire risks at intervals established by the organization. Evidence of unsafe practices leading to potential risk is used to establish these intervals. Document the reevaluation of potential fire risks.	OME			
3	Inform and educate the patient, family, and/or caregiver about the following: ■ The findings of the safety risk assessment ■ The causes of fire ■ Fire risks for neighboring residences and buildings ■ Precautions that can prevent fire-related injuries ■ Recommendations to address the specific identified risk(s) Document the provision of information and education.	OME			
4	Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.	OME			
5	Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance.	OME			

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

UP.01.01.01: Conduct a preprocedure verification process.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.	AHC, CAH, HAP, OBS			

(continued on page 25)

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2	Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following: ■ 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 procedures	AHC, CAH, HAP, OBS			
3	Match the items that are to be available in hte procedure area to the patient.	AHC, CAH, HAP, OBS			

UP.01.02.01: Mark the procedure site.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.	AHC, CAH, HAP, OBS			
2	Mark the procedure site before the procedure is performed and, if possible, with the patient involved.	AHC, CAH, HAP, OBS			
3	The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications: ■ An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed ■ A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.	AHC, CAH, HAP, OBS			

(continued on page 26)

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4	The method of marking the site and the type of mark is unambiguous and is used consistently throughout the organization.				
5	A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).	AHC, CAH, HAP, OBS			

UP.03.01.01: A time-out is performed before the procedure.

EP	Requirement	Applies to:	In compliance?	Actions Taken	Results of Actions Taken
1	Conduct a time-out immediately before starting the invasive procedure or making the incision.	AHC, CAH, HAP, OBS			
2	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.	AHC, CAH, HAP, OBS			
3	When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.	AHC, CAH, HAP, OBS			
4	During the time-out, the team members agree, at a minimum, on the following: ■ Correct patient identity ■ The correct site ■ The procedure to be done	AHC, CAH, HAP, OBS			
5	Document the completion of the time-out.	AHC, CAH, HAP, OBS			

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