EP 7 The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.

Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.

Introduction to Reconciling Medication Information

The large number of people receiving health care who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a physician or other licensed practitioner compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.

The Joint Commission recognizes that organizations face challenges with medication reconciliation. The best medication reconciliation requires a complete understanding of what the patient was prescribed and what medications the patient is actually taking. It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As health care evolves with the adoption of more sophisticated systems (such as centralized databases for prescribing and collecting medication information), the effectiveness of these processes will grow.

This National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are designed to help organizations reduce negative patient outcomes associated with medication discrepancies. Some aspects of the care process that involve the management of medications are addressed in the standards rather than in this goal. These include coordinating information during transitions in care both within and outside of the organization (PC.02.02.01), patient education on safe medication use (PC.02.03.01), and communications with other providers (PC.04.02.01).

In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide to patients. It is often important for physicians and other licensed practitioners to know what medications the patient is taking when planning care, treatment, and services, even in situations where medications are not used.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

--Rationale for NPSG.03.06.01--

There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that physicians and other licensed practitioners use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected in order to reconcile current and newly ordered medications and to safely prescribe medications in the future.

Element(s) of performance for NPSG.03.06.01

EP 1 Obtain information on the medications the patient is currently taking when they are admitted to the hospital 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.

Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.

Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

Documentation is required.

EP 2 Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings.

Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.

EP 3 Compare the medication information the patient brought to the hom ᶠ ⌠ ꝇpl' Sećons. ᵠᴰla a ph ⲨᵐᴀMƙÄro t

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--Rationale for NPSG.06.01.01--

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety.

Note: Additional information on alarm safety can be found on the AAMI website.

Element(s) of performance for NPSG.06.01.01

EP 1 Leaders establish alarm system safety as a hospital priority.

EP 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

(For more information on managing medical equipment risks, refer to Standard EC.02.04.01)

EP 3 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

(For more information, refer to Standard EC.02.04.03)

Documentation is required.

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 and/or the current World Health Organization (WHO) hand hygiene guidelines.

--Rationale for NPSG.07.01.01--

According to the Centers for Disease Control and Prevention, ea

Goal 16

Improve health care equity.

Introduction to NPSG.16.01.01

Although health care disparities are often viewed through the lens of social injustice, they are first and foremost a quality of care problem. Like medication errors, health care–acquired infections, and falls, health care disparities must be examined, the root causes understood, and the causes addressed with targeted interventions. Organizations need established leaders and standardized structures and processes in place to detect and address health care disparities. These efforts should be fully integrated with existing quality improvement activities within the organization, such as activities related to infection prevention and control, antibiotic stewardship, and workplace violence.

The elements of performance (EPs) in National Patient Safety Goal NPSG.16.01.01 focus on fundamental processes that will help organizations address health care equity as a quality and safety issue (that is, identifying a leader, understanding
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Element(s) of performance for NPSG.16.01.01

EP 1 The hospital designates an individual(s) to lead activities to improve health care equity for the hospital's patients.

Note: Leading the hospital's activities to improve health care equity may be an individual's primary role or part of a broader set of responsibilities.

EP 2 The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.

Note 1: Hospitals determine which HRSNs to include in the patient assessment. Examples of a patient's HRSNs may include the following:

- Access to transportation
- Difficulty paying for prescriptions or medical bills
- Education and literacy
- Food insecurity
- Housing insecurity

Note 2: HRSNs may be identified for a representative sample of the hospital's patients or for all the hospital's patients.

Documentation is required.

EP 3 The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.

Note 1: Hospitals may focus on areas with known health care disparities identified in the scientific literature (for example, organ transplantation, maternal care, diabetes management) or select measures that affect all patients (for example, experience of care and communication).

Note 2: Hospitals determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following:

- Age
- Gender
- Preferred language
- Race and ethnicity

Documentation is required.

EP 4 The hospital develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.

Documentation is required.

EP 5 The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity.

Documentation is required.

- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital 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.

Element(s) of performance for UP.01.01.01

EP 1 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.

EP 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 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.

Documentation is required.

Introduction to UP.01.02.01

Wrong-site surgery should never happen, yet it is an ongoing problem in health care that compromises patient safety. Marking the procedure site is one way to protect patients; patient safety is enhanced when a consistent marking process is used throughout the hospital. Site marking is done to prevent errors when there is more than one possible location for a procedure. Examples include different limbs, fingers and toes, lesions, level of the spine, and organs. In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

UP.01.02.01

Mark the procedure site.

Element(s) of performance for UP.01.02.01

EP 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

--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. A hospital 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 hospital.

Element(s) of performance for UP.01.03.01

EP 1 Conduct a time-out immediately before starting the invasive procedure or making the incision.

EP 2 The time-out has the following characteristics:

- It is standardized, as defined by the hospital.
- 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.

EP 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.

EP 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

EP 5 Document the completion of the time-out.

Note: The hospital determines the amount and type of documentation.

Documentation is required.