Goal 1
Improve the accuracy of patient identification.

Requirement 1A
Use at least two patient identifiers when providing care, treatment or services.

Rationale for Requirement 1A
Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. The intent for this goal is two-fold; first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that individual.

Implementation Expectations for Requirement 1A:
1. Two patient identifiers are used when administering medications or blood products
2. Two patient identifiers are used when collecting blood samples and other specimens for clinical testing.
3. Two patient identifiers are used when providing other treatments or procedures
4. The patient’s room number or physical location is not used as an identifier.
5. Containers used for blood and other specimens are labeled in the presence of the patient.
6. Prior to any venipuncture, arterial puncture, or capillary blood collection procedure, the patient should be actively involved in the identification process when possible.

Requirement 1C
Eliminate transfusion errors related to patient misidentification.

Implementation Expectations for Requirement 1C:
1. Before initiating a blood product transfusion, the patient is matched to the blood product and the blood product is matched to the order using either a two person verification process or an automated identification technology such as bar coding.
2. When using a two-person verification process, one individual conducting the identification verification must be the qualified transfusionist who will administer the blood product to the patient.
3. When using a two-person verification process, the second individual conducting the identification verification must be qualified to perform this task.
Goal 7
Reduce the risk of health care-associated infections.

The proposed 2009 National Patient Safety Goal (NPSG) topics are undergoing the annual cycle of development. For 2009, there are topics that relate to Healthcare Associated Infections (HAI). The Joint Commission has been a participant with the recent Healthcare Associated Infection (HAI) – Allied Task Force, which will soon release guidelines on several HAI topics. The 2009 NPSG topics that are HAI-related endeavor to be consistent with these new guidelines but are not identical in their format. The guidelines were written for acute care hospitals, but the Joint Commission expanded the applicability to other settings in some cases. These guidelines are scheduled to be published in a special edition to The Society for Healthcare Epidemiology of America’s (SHEA) official journal, Infection Control and Hospital Epidemiology, in April 2008. The Guidelines are also scheduled to be published electronically by SHEA in March 2008.

Requirement 7C
Implement best practices to facilitate the prevention of multiple drug resistant organisms (MDRO) infections in acute care hospitals, focusing on methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*-associated disease (CDAD).

Implementation Expectations for Requirement 7C:
**General**
1. Educate health care workers about MDRO and the necessity for prevention
2. Measure MRSA and CDAD infection rates, monitor compliance with best practices, and evaluate the effectiveness of prevention efforts.
3. Provide MRSA and CDAD infection rate data and prevention outcome measures to key stakeholders including senior hospital leadership, physicians, nursing staff, and other clinicians
4. Educate patients and their families about MRSA and CDAD prevention

Methicillin-resistant *Staphylococcus aureus*
5. Conduct a risk assessment for MRSA incidence, prevalence, acquisition, and transmission.
6. Implement hand hygiene practices (see NPSG 7A).
7. Use contact precautions for patients with MRSA to reduce patient-to patient spread of infection. (See IC.4.10., EP4)
8. Effectively clean and disinfect patient care equipment and the patient care environment based on standards identified by the organization. (See IC.4.10, EP 3)
9. Implement a MRSA surveillance program to identify and track patients with clinical or active surveillance culture/testing specimen positive results for MRSA.
10. Implement a laboratory-based alert system that identifies new patients with MRSA.
11. Implement an alert system that identifies readmitted or transferred MRSA-positive patients

*Clostridium difficile*-associated disease

12. Conduct a risk assessment for CDAD incidence, prevalence, acquisition, and transmission.

13. Implement hand hygiene practices (see NPSG 7A).

14. Use contact precautions for patients with CDAD to reduce patient-to-patient spread of infection. (See IC.4.10., EP4)

15. Effectively clean and disinfect patient care equipment and the patient care environment. (See IC.4.10, EP 3)

16. Implement a CDAD surveillance program.

**Requirement 7D**

Implement best practices for prevention of catheter-associated bloodstream infections (CABSI)

**Implementation Expectations for Requirement 7D:**

**General**

1. Educate health care workers about CABSI and the necessity for prevention.

2. Measure CABSI rates, monitor compliance with best practices, and evaluate the effectiveness of prevention efforts.

3. Provide CABSI rate data and prevention outcome measures to key stakeholders including senior leadership licensed independent practitioners, nursing staff, and other clinicians.

4. Educate patients and their families about CABSI prevention.

**Before insertion**

5. Reinforce the education of healthcare personnel about CABSI prevention and the care of central venous lines.

**At insertion**

6. Use a catheter checklist and a standardized protocol for central venous catheter insertion.

7. Perform hand hygiene prior to catheter insertion or manipulation (see NPSG 7A).

8. Avoid using the femoral vein, if possible, for central venous access in adult patients.

9. Use a standardized supply cart or kit that is all inclusive for the insertion of central lines.
10. Use a standardized protocol for maximum sterile barrier precautions during central venous catheter insertion.

11. Use a chlorhexidine-based antiseptic for skin preparation in patients over 2 months of age.

After insertion

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.

13. Evaluate all central lines daily and remove non-essential catheters.

Requirement 7E
Implement best practices for prevention of surgical site infections (SSI).

Implementation Expectations for Requirement 7E:
General
1. Educate health care workers about SSI and the necessity for prevention.

2. Measure SSI rates, monitor compliance with best practices, and evaluate the effectiveness of prevention efforts.

3. Provide SSI rate data and prevention outcome measures to key stakeholders including senior leadership, licensed independent practitioners, nursing staff, and other clinicians.

4. Implement policies and practices aimed at reducing the risk of SSI that meet regulatory and accreditation requirements and are aligned with evidence-based standards (e.g. CDC and professional organization guidelines)

5. Educate patients and their families about SSI prevention.

Specific
6. Administer antimicrobial agents for prophylaxis with a particular procedure or disease according to standards and guidelines for best practices:

   a. Deliver intravenous antimicrobial prophylaxis within 1 hour before incision [2 hours are allowed for the administration of vancomycin and fluoroquinolones]. (See Joint Commission core measures at www.jointcommission.org/performance measurement.)

   b. Discontinue the prophylactic antimicrobial agent within 24 hours after surgery [within 48 hours is allowable for cardiothoracic procedures]. (See Joint Commission core measures at www.jointcommission.org/performance measurement.)

7. Shaving is an inappropriate hair removal method. When hair removal is necessary, use clippers or depilatories

8. Maintain optimal control of blood glucose levels (as defined by the organization) with standardized protocols during the peri-operative period for surgical procedures
References

References are included within the guidelines developed by the Healthcare-Associated Infection Task Force. The Guidelines will be released this spring.

The revisions made in Goal 8 consist of new and revised requirements and implementation expectations. The revised goal contains the same concepts as the previous version. The revisions to the goal have been made in an attempt to clarify the requirements. All new additions to the goal are underlined.

Goal 8
Accurately and completely reconcile patient medications across the continuum of care.

Requirement 8A
There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.

Rationale for Requirement 8A
Patients are at high risk for harm from adverse drug events when communication about medications is not clear during transitions in patient care. These transitions or hand-offs occur across settings, services, providers, or levels of care. Obtaining, maintaining and communicating an accurate medication list that reconciles any medication list discrepancies whenever new medications are ordered, or current medications are adjusted, is essential to reducing the risk of transition-related adverse drug events.

Implementation Expectations for Requirement 8A
1. The organization, with the patient’s involvement and/or the patient’s family as needed, creates and documents a complete list of the patient’s current medications at the time of entry to the organization or admission.
2. 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.
3. Any discrepancies (e.g. omissions, duplications, potential interactions) are reconciled concurrently during the patient’s stay and documented.
4. During transitions in care within the organization, communication between the patient’s providers regarding the most up-to-date reconciled medication list occurs and is documented.

Requirement 8B
When a patient is referred 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 directly to his or her home, the complete and reconciled list of medications is provided to the patient’s known primary care provider, or the original referring provider, or a known next provider of service.
**Rationale for Requirement 8B**
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. This ensures that the next provider of service has a thorough knowledge of the patient’s medications and can safely order/prescribe other medications that may be needed. This is especially important at transitions in care when a patient is referred or transferred from one organization to another. NOTE: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the patient the list of medications is sufficient.

**Implementation Expectations for Requirement 8B**
1. The patient’s most current reconciled medication list, and a listing of the original home medications at the time of entry to the organization, is communicated to the next provider of service. The communication between providers is documented.
2. At the time of transfer, the transferring organization informs the next provider of service how to obtain clarification of the medication lists.

**Requirement 8C**
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/or the patient’s family as needed, and the list is explained to the patient and/or family.

**Rationale for Requirement 8C**
The accurate communication of the patient’s medication list to the patient, and/or to the patient’s family if needed, reduces the risk of transition-related adverse drug events and is essential for ensuring that the patient’s primary care provider or next provider of service can manage the subsequent stages of care for the patient with a thorough knowledge of the patient’s medications. . NOTE: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the patient the list of medications is sufficient.

**Implementation Expectations for Requirement 8C**
1. When the patient leaves the organization’s care, the current list of reconciled medications is provided to the patient, is explained to the patient and the interaction is documented.

**Requirement 8D**
In settings where medications are not used, are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

**Rationale for 8D**
There are a number of patient care settings in which the medications are not used, are used minimally, or prescribed for a short duration. Examples of these include areas such as urgent and emergent care office-based surgery, outpatient radiology, ambulatory care, and behavioral health care. In these settings obtaining a list of the patient’s known medications currently taken at home is still important but it does not necessarily require obtaining information on the dose, route and frequency for use of the patient’s current medications. A new list of the known, current medications does not need to be provided to patients when they leave these setting, unless the patient is
assessed to be confused or unable to comprehend adequately. In this case, the patient's family is provided the medication list and the circumstances documented.

1. 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 (e.g., IV contrast, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.

2. If no changes are made to the patient's current medication list, or when only short-term medications (e.g., 5 days of an antibiotic) will be prescribed, the patient is provided with a list containing the short-term medication additions.

In these settings, there is a complete, documented medication reconciliation process when

3. Any new long-term (chronic) medications are prescribed.

4. There is a prescription change for any of the patient's current long-term medications

5. The patient is required to be subsequently admitted to an organization from these settings for ongoing care.

6. When a complete, documented medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient and the patient's family as needed, and to the patient's primary care provider or original referring provider.
Goal 13
Encourage patients' active involvement in their own care as a patient safety strategy.

Requirement 13A
Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

Rationale for Requirement 13A
Communication with patients and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When patients know what to expect, they are more aware of possible errors and choices. Patients can be an important source of information about potential adverse events and hazardous conditions.

Implementation Expectation for Requirement 13A
1. Patients and families are educated on methods available to report concerns related to care, treatment, services and patient safety issues.

2. The organization encourages patients and their families to report concerns about safety.

3. The organization provides patients with information regarding infection control measures for hand hygiene practices, respiratory hygiene practices and contact precautions as appropriate to the patient's condition. The information is discussed with the patient and family members on the day the patient enters the organization. Note: The information may be written or recorded. (See RI.2.90 regarding information on the outcomes of care)

4. The organization provides surgical patients with information on the prevention of adverse events in surgery. Note: examples include, but are not limited to, patient identification practices, marking of the procedure sites, clarifying medication lists.

Universal Protocol

The revisions made to the Universal Protocol consist of revised implementation expectations. The revised Universal Protocol contains the same concepts as the previous version. The revisions and additions have been made in an attempt to clarify the requirements. All additions to the implementation expectations are underlined.

Requirement 1A
Conduct a preoperative verification process

Implementation Expectations
1. Verification of the correct person, procedure, and site occurs:
   • At the time the surgery/procedure is scheduled.
   • At the time of preadmission testing and assessment.
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- At the time of admission or entry into the facility for a procedure – elective or emergent.
- Before the patient leaves the pre-operative area or enters the procedure/surgical room.
- Anytime the responsibility for care of the patient is transferred to another caregiver, including the anesthesia providers at the time of, and during, the procedure.
- With the patient involved, awake and aware, if possible.

2. **A preoperative verification checklist (hard-copy or electronic) is used to review and ensure availability of the following items prior to the start of the procedure:**
   - Relevant documentation (e.g., H&P, consent, nursing and pre-anesthesia assessments).
   - Relevant and appropriate diagnostic and radiology test results (e.g., radiology images and scans or pathology and biopsy reports).
   - Relevant images and results are properly labeled and able to be appropriately displayed.
   - Confirming the on-site availability of any required implants, devices and/or special equipment for the procedure.

**Requirement 1B**
Mark the operative site

**Implementation Expectations**

1. Mark all cases involving incision, percutaneous instrumentation or placement of instruments through a natural orifice with specific attention to laterality, surface (flexor, extensor), level (spine), or specific digit or lesion to be treated.

2. The site is initially marked before the patient is moved to the location where the procedure will be performed.

3. Marking takes place with the patient involved, awake and aware, if possible.

4. A licensed independent practitioner who will be involved directly with, and present at the time of performing the procedure, marks the procedure site.

5. The mark is made at or near the intended incision site. Do not mark any non-operative site(s) unless necessary for some other aspect of care.

6. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the organization, preferably with the surgeon’s or proceduralist’s initials, with or without a line representing the proposed incision.

7. The mark is made using a marker that is sufficiently permanent to remain visible after completion of the skin prep and sterile draping (Note: adhesive site markers are not to be used as the sole means of marking the site).

8. The mark is positioned to be visible after the patient’s skin is prepped, the patient is positioned, and sterile draping completed.
9. For spinal procedures, in addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.

10. For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side must be indicated by a mark at or near the insertion site, and remains visible after completion of the skin prep and sterile draping (see the note below for alternative approaches, where appropriate).

11. Final confirmation and verification of the site mark takes place during the “time out.”

12. A defined procedure is in place for patients who refuse site marking or who are unable to be marked. Alternative approaches for site marking may be used for the following:
   - Premature infants, for whom the mark may cause a permanent tattoo.
   - Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., cardiac catheterization, pacemaker insertion, and dialysis catheters.)
   - Teeth—but the operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.
   - For cases in which it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, premature infants), an alternative method for visually identifying the correct side is used: a temporary unique wrist band on the side of the procedure, which contains the patient's name, a second identifier, the intended procedure and site.)

**Requirement 1C**
Conduct a final “Time out” verification immediately before starting the procedure

**Implementation Expectations**
1. This final procedure verification step is conducted prior to starting the actual procedure, in the location where the procedure will be performed, and with the patient properly positioned for the procedure (Note: this includes a review of the signed informed consent) verifying the correct procedure(s), laterality and site(s).

2. The “time out” must be initiated in a standardized fashion, as defined by the organization, and involves all the individuals of the entire procedure team who will be participating with the procedure at its inception.
3. Interactive verbal communication between all team members, and the ability for any team member to express concerns about the procedure verification, is promoted.

4. During the “time out,” other activities are suspended—to the extent possible without compromising the safety of the patient—so that all members of the team are focused on the active verification of the correct patient, procedure, site, and other critical elements.

5. There is a defined process for reconciling differences in responses during the “time out.”

6. When two or more procedures are being performed on the same patient, a “time-out” is performed to verify each subsequent procedure before they are initiated.

7. The “time out” must, at the least, include:
   - Correct patient identity
   - Correct side and site
   - Agreement on the procedure to be done
   - Correct patient position
   - Availability of appropriate diagnostic and radiology test results (e.g., radiology images and scans or pathology and biopsy reports).
   - Relevant images and results are properly labeled and appropriately displayed.
   - Availability of correct implants, devices and any special equipment or special requirements
   - Need for special medications or fluids for irrigation purposes.
   - Safety precautions based on patient history or medication use.

8. The completed components of the Universal Protocol and “time-out” are clearly documented on the pre-procedure checklist.