National Patient Safety Goals Effective January 2021 for the Critical Access Hospital Program

Goal 1

Improve the accuracy of patient identification.

NPSG.01.01.01

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

--Rationale for NPSG.01.01.01--

Wrong-patient errors 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.

Newborns are at higher risk of misidentification due to their inability to speak and lack of distinguishable features. In addition to well-known misidentification errors such as wrong patient/wrong procedure, misidentification has also resulted in feeding a mother's expressed breastmilk to the wrong newborn, which poses a risk of passing bodily fluids and potential pathogens to the newborn. A reliable identification system among all providers is necessary to prevent errors.

Element(s) of Performance for NPSG.01.01.01

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. (See also PC.02.01.01, EP 10) R
2. Label containers used for blood and other specimens in the presence of the patient. (See also PC.02.01.01, EP 10) R
3. Use distinct methods of identification for newborn patients. R
   Note: Examples of methods to prevent misidentification may include the following:
   - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example: "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples).
   - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification).
   - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).

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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.

--Rationale for NPSG.02.03.01--

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.

Element(s) of Performance for NPSG.02.03.01

1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following: R D
   - 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
2. Implement the procedures for managing the critical results of tests and diagnostic procedures. R
3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures. R

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

--Rationale for NPSG.03.04.01--

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 Standard MM.05.01.09.

Element(s) of Performance for NPSG.03.04.01

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. R
   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.

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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. R

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: R
   - 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

   Note: The date and time are not necessary for short procedures, as defined by the critical access hospital.

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. R

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered. R
   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.

6. Immediately discard any medication or solution found unlabeled. R

7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure. R
   Note: This does not apply to multiuse vials that are handled according to infection control practices.

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. R

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NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.
Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).

--Rationale for NPSG.03.05.01--

Anticoagulation therapy can be used as therapeutic treatment for several 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 anticoagulant 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 patients on this class of medications, including improving patient outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy and the precautions they need to take. 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, warfarin, and direct oral anticoagulants (DOACs).

Element(s) of Performance for NPSG.03.05.01

1. The critical access hospital uses approved protocols and evidence-based practice guidelines for the initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug–drug and drug–food interactions; and other risk factors as applicable. R
2. The critical access hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication. R
3. The critical access hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants. R
   Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.
4. The critical access hospital has a written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy. R D
   Note: For all patients receiving warfarin therapy, use a current international normalized ratio (INR) to monitor and adjust dosage. For patients on a direct oral anticoagulant (DOAC), follow evidence-based practice guidelines regarding the need for laboratory testing.
5. The critical access hospital addresses anticoagulation safety practices through the following: R
   - Establishing a process to identify, respond to, and report adverse drug events, including adverse drug event outcomes
   - Evaluating anticoagulation safety practices, taking actions to improve safety practices, and measuring the effectiveness of those actions in a time frame determined by the critical access hospital
6. The critical access hospital provides education to patients and families specific to the anticoagulant medication prescribed, including the following: R
   - Adherence to medication dose and schedule
   - Importance of follow-up appointments and laboratory testing (if applicable)
   - Potential drug–drug and drug–food interactions
   - The potential for adverse drug reactions

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7. The critical access 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.

8. When heparin is administered intravenously and continuously, the critical access hospital uses programmable pumps in order to provide consistent and accurate dosing.

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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 clinician 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 clinicians 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 clinicians 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

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the critical access 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. R D
   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.

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2. Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings. R
   Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.
3. Compare the medication information the patient brought to the critical access hospital with the medications ordered for the patient by the critical access hospital in order to identify and resolve discrepancies. R
   Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the critical access hospital, does the comparison. (See also HR.01.06.01, EP 1)
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 critical access hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose). R D
5. Explain the importance of managing medication information to the patient when he or she is discharged from the critical access hospital or at the end of an outpatient encounter. R
   Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

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Goal 6

Reduce patient harm associated with clinical alarm systems.

NPSG.06.01.01

Improve the safety of clinical alarm systems.

--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 critical access hospitals and even within different units in a single critical access 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 critical access 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 https://www.aamifoundation.org/coalitions/clinical-alarm-systems/complementary-research/.

Element(s) of Performance for NPSG.06.01.01

1. Leaders establish alarm system safety as a critical access hospital priority. R

2. Identify the most important alarm signals to manage based on the following: R
   - 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)

3. Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: R D
   - 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)

4. Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible. R

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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, 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 patients, 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, monitors compliance, and provides feedback.

Element(s) of Performance for NPSG.07.01.01

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. (See also IC.01.04.01, EP 1) R
2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 1) R
3. Improve compliance with hand hygiene guidelines based on established goals. R

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Goal 15

The critical access hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01

Reduce the risk for suicide.
Note: EPs 2–7 apply to patients in psychiatric distinct part units in critical access hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care in critical access hospitals. In addition, EPs 3–7 apply to all patients who express suicidal ideation during the course of care.

Element(s) of Performance for NPSG.15.01.01

1. For psychiatric distinct part units in critical access hospitals: The critical access hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the critical access hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). R D

   For nonpsychiatric units in critical access hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the critical access hospital.
   Note: Nonpsychiatric units in critical access hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).
2. Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. R
   Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.
3. Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. R
   Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.
4. Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide. R
5. Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following: R D
   - Training and competence assessment of staff who care for patients at risk for suicide
   - Guidelines for reassessment
   - Monitoring patients who are at high risk for suicide
6. Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide. R
7. Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance. R

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

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Critical access hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:
- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and, as needed, the family are involved in the process.
- Consistent implementation of a standardized protocol is most effective in achieving safety.

The Universal Protocol is implemented most successfully in critical access hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. A critical access hospital should consider its culture when designing processes to meet the Universal Protocol. In some critical access hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements.

Critical access hospitals should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time-out). Preprocedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the critical access hospital.

Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

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UP.01.01.01

Conduct a preprocedure verification process.

--Rationale for UP.01.01.01--

Critical access hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are as follows:
- 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 critical access 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

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. R
   Note: The patient is involved in the verification process when possible.
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: R D
   - 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.
3. Match the items that are to be available in the procedure area to the patient. R

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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 critical access 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.

Responsibility for marking the procedure site is a hotly debated topic. One position is that since the licensed independent practitioner is accountable for the procedure, he or she should mark the site. Another position is that other individuals should be able to mark the site in the interests of work flow and efficiency.

There is no evidence that patient safety is affected by the job function of the individual who marks the site. The incidence of wrong-site surgery is low enough that it is unlikely that valid data on this subject will ever be available. Furthermore, there is no clear consensus in the field on who should mark the site. Rather than remaining silent on the subject of site marking, The Joint Commission sought a solution that supports the purpose of the site mark. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. In most cases, that will be the person performing the procedure.

Recognizing the complexities of the work processes supporting invasive procedures, The Joint Commission believes that delegation of site marking to another individual is acceptable in limited situations as long as the individual is familiar with the patient and involved in the procedure. These individuals would include the following:
- Individuals who are permitted through a postgraduate education program to participate in the procedure.
- A licensed individual who performs duties requiring collaborative or supervisory agreements with a licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs).

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.

UP.01.02.01

Mark the procedure site.

Element(s) of Performance for UP.01.02.01

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. Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.	R
2.	Mark the procedure site before the procedure is performed and, if possible, with the patient involved.	R

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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: R
   - 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.
   Note: The critical access hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.
4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the critical access hospital. R
   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.
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). R D
   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
   - Teeth
   - Premature infants, for whom the mark may cause a permanent tattoo

UP.01.03.01

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. A critical access 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 critical access hospital.

Element(s) of Performance for UP.01.03.01

1. Conduct a time-out immediately before starting the invasive procedure or making the incision. R
2. The time-out has the following characteristics: R
   - It is standardized, as defined by the critical access 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.
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. R

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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

5. Document the completion of the time-out.
   Note: The critical access hospital determines the amount and type of documentation.

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