The Joint Commission Announces the 2008 National Patient Safety Goals and Requirements

The Joint Commission’s Sentinel Event Advisory Group recommended National Patient Safety Goals and associated requirements for 2008. The Joint Commission’s Board of Commissioners adopted these recommendations at its June 2007 meeting and established a January 1, 2008, effective date for the new goals and requirements. The 2008 goals and requirements are provided in the box beginning on page 10.

Each year, the Joint Commission develops National Patient Safety Goals specific to each of its accreditation programs and the disease-specific care certification program. The 2008 National Patient Safety Goals apply (as indicated on the following pages) to the ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospital, laboratory, long term care, Medicare/Medicaid certification-based long term care, and office-based surgery programs, and health care networks.

Major changes in this sixth annual issuance of National Patient Safety Goals include the following:

- The addition of Requirement 3E to Goal 3 that addresses the management of anticoagulant therapy, applicable to the ambulatory care, critical access hospital, home care, hospital, long term care, and office-based surgery programs. The implementation expectations for Requirement 3E have been adapted to address program-specific issues. (See pages 13–14.)
- The addition of Goal 16 and Requirement 16A that address early recognition and response to changes in patient condition, applicable to the critical access hospital and hospital programs. (See page 19.)

Continued on page 9
In Sight

This column informs you of developments and potential revisions that can affect your accreditation and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they were rejected at some point in the process.

APPROVED

- 2008 National Patient Safety Goals for the ambulatory care, critical access hospital, home care, hospital, long term care, and Medicare/Medicaid-based long term care programs effective January 1, 2008 (see pages 10–22 in this issue)
- Revisions to Standard MS.1.20 regarding medical staff bylaws for the critical access hospital and hospital programs effective July 1, 2009 (see an upcoming issue of Perspectives for more information)
- Revisions to the “Leadership” (LD) chapter for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, and office-based surgery programs effective January 1, 2009 (see an upcoming issue of Perspectives for more information)

JOINT COMMISSION FIELD REVIEW

Field review notifications are sent out electronically, as well as posted on The Joint Commission Web site. If you would like to be added to the electronic notification list, please contact the Division of Standards and Survey Methods at 630/792-5912.

- Standards Improvement Initiative: Revised “Management of Human Resources” (HR) chapter for the ambulatory care, critical access hospital, hospital, home care, and office-based surgery programs

IN COMMITTEE OR BOARD REVIEW

- Review of the Disease-Specific Care program standards to determine the need for revisions and address needed editorial changes to standards and addenda and the order of the chapters
- Health Care Staffing Services manual revision to clarify standards and elements of performance
- Transplant Center certification program standards to recognize the unique care needs of solid organ (for example, kidney, liver, heart) transplant patients

CURRENTLY IN DEVELOPMENT

- Development of an advanced Disease-Specific Care certification program for Chronic Obstructive Pulmonary Disease
- Development of a Health Care Services Certification Program for services such as palliative care
- Comprehensive Standards Improvement Initiative encompassing the ambulatory care, critical access hospital, home care, hospital, and office-based surgery programs
- Proposed revisions to medication management standards MM.4.10 and MM.8.10 for the critical access hospital and hospital programs
- Potential 2009 National Patient Safety Goals
UPDATE: Standard MM 4.10, EP 1 in the Emergency Department—Interim Action Suspended Effective Immediately

Effective April 6, 2007, The Joint Commission suspended the interim action for Standard MM.4.10, Element of Performance 1 that required a retrospective review of all medication orders in the emergency department (ED) by a pharmacist when a prospective review was not conducted. The interim action was implemented on January 1, 2007, for EDs in hospitals and critical access hospitals (as originally published in the January 2007 issue of Joint Commission Perspectives®).

The decision to suspend the interim action was based on several concerns cited by the field, including the lack of prior hospital pharmacist involvement in the ED setting, the costs to hospitals of providing additional pharmacist manpower to support medication review of any type in the ED, and the frequent unavailability of pharmacists because of the long-standing pharmacist shortage.

With the suspension of the interim action, the requirement for Standard MM.4.10, EP 1 will be re-instated as previously written in the 2007 Comprehensive Accreditation Manual for Hospitals: The Official Handbook and Comprehensive Accreditation Manual for Critical Access Hospitals, which states the following:

Before dispensing, (critical access hospital: when on-site pharmacy services are available,) removal from floor stock, or removal from an automated storage and distribution device, a pharmacist reviews all prescription or medication orders unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication; or in urgent situations when the resulting delay would harm the patient, including situations in which the patient experiences a sudden change in clinical status (for example, new onset of nausea).

However, the Joint Commission will now permit organizations to implement the two exceptions in Standard MM.4.10, EP 1 more broadly in order to minimize treatment delays and patient back-up. To clarify this position, each exception is addressed below emphasizing its implementation in the ED:

• Exception 1: “…unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication.”

Implementation: When using this exception, medications ordered by a licensed independent practitioner in the ED can be processed, including administration of the medication, by a registered nurse or other licensed staff with medication administration responsibilities (for example, respiratory therapist) in accordance with law and regulation. A licensed independent practitioner will not be required to remain at the bedside when the medication is administered. However, the licensed independent practitioner must remain available to provide immediate intervention should a patient experience an adverse medication event.

• Exception 2: “…in urgent situations when the resulting delay would harm the patient, including situations in which the patient experiences a sudden change in clinical status.”

Implementation: When using this exception, urgent care situations will be defined by the licensed independent practitioner who is providing care to the patient.

The broad implementation of the two exceptions to Standard MM.4.10, EP 1, will remain in effect for EDs while this standard is under revision and further tested in the field. Organizations that have successfully implemented prospective medication order review by a pharmacist are encouraged to continue doing so whenever possible.

Two further actions are underway by the Joint Commission to resolve the issues pertaining to Standard MM.4.10 in the ED, as follows:

1. The Joint Commission is convening an interdisciplinary task force to review the recommendations from stakeholders and the 2006 field review of Standard MM.4.10, EP 1, in the ED, and to develop a proposal for revisions to this standard.
2. An additional field review will be planned to obtain field input on proposed strategies to revise Standard MM.4.10, EP 1.

The Joint Commission will host a free audio conference on Standard MM.4.10 on Wednesday, July 18, 2007 beginning at 9:30 A.M. PT / 10:30 A.M. MT / 11:30 A.M. CT / 12:30 P.M. ET. Registration information will be sent to accredited hospitals and critical access hospitals via list-serve approximately one week prior to the call. To sign up to receive registration information, visit your organization’s extranet site on The Joint Commission Connect™.

Please direct questions to the Standards Interpretation Group at 630/792-5900, option 6, or through the online submission form at http://www.jointcommission.org/Standards/OnlineQuestionForm.
**APPROVED: Revisions to Contracted Services Standard LD.3.50**

The Joint Commission has approved revisions to Standard LD.3.50, addressing contracted services. These revisions, effective January 1, 2008, apply to the ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, Medicare/Medicaid-based long term care, and office-based surgery programs. Revisions to the standard are shown on pages 6–8 in underlined text. A detailed discussion of the changes to this standard follows, as well as a question and answer section.

**Overview of Standard LD.3.50 and Revisions**

Standard LD.3.50 outlines the steps that should be taken to oversee services provided through contractual agreements* with individuals or organizations. Revisions to this standard have been made to provide better guidance regarding leaders' responsibilities for overseeing contracted services. The revisions to this standard are intended to clarify the accreditation requirements and are not intended as a legal primer for managing contracts or to replace the contract management systems that many organizations already have in place.

As outsourcing becomes more common in health care, the Joint Commission maintains that the patient, client, or resident should receive the same high degree of quality and safety regardless of whether care, treatment, or services are provided by the organization's staff or through contractual agreement. Hence, Standard LD.3.50 specifically addresses the oversight of care, treatment, and services provided to patients, clients, or residents through contractual agreements. The revised elements of performance (EPs) for Standard LD.3.50 address the following activities:

- Selection and approval of sources for contracted services
- Setting expectations for the contractor's performance
- Evaluation of whether the expectations were met
- Steps toward improvement if expectations were not met
- Maintenance of continuity of care when a contract is terminated or renegotiated

In addition, Standard LD.3.50 still includes EPs that are unique to reference laboratories, critical access hospitals, home health agencies, and hospices. These EPs were not revised.

**Questions and Answers about Standard LD.3.50**

**Q** Is Standard LD.3.50 applicable for all contracts?

**A** No, not all contracts need to comply with Standard LD.3.50. The Joint Commission recognizes that organizations contract for a wide variety of products and services. As a matter of good business practice, leaders typically have a variety of procedures available for oversight of contracts. However, the only contractual agreements that are subject to Standard LD.3.50 are those that are for care, treatment, and services provided to the organization's patients, clients, or residents.

For example, Standard LD.3.50 does not apply to the following types of contractual agreements:

- Administrative services such as billing, marketing, and management consulting
- Supply and environmental support such as materials management, landscaping, security, and waste management

Even though these types of contracts are not subject to Standard LD.3.50, they must meet other standards appropriate to the service provided. For example, a security services contractor would need to provide the service in accordance with the security requirements of Standard EC.2.10.

**Q** Aside from Standard LD.3.50, do any other standards apply when care, treatment, and services are provided under contractual agreement?

**A** Yes, other standards do apply. While Standard LD.3.50 specifies an organization's responsibilities for contract management, it does not replace the need for the contracted individual or organization to provide care, treatment, and services in a way that complies with Joint Commission standards. Your organization's accreditation decision is based on its compliance with standards, National Patient Safety Goals, and Accreditation Participation Requirements regardless of whether care, treatment, and services are delivered directly by employ-

* Throughout this article and the revised standard, the term **contractual agreement** is used. For the purposes of accreditation, a contractual agreement is considered to be an agreement with any organization, group, agency, or individual for services or personnel to be provided by, to, or on behalf of the organization. Such agreements are defined in a contract or in some other form of written agreement. Other terms used in this article and the standard that are intended to have the same meaning as contractual agreement are as follows: contract, contracted services, contractual services, memorandum of understanding, letter of agreement, and written agreement.
ees or through contractual agreements. Therefore, con-
tacted services are included when evaluating compli-
ance with Joint Commission requirements either during
the on-site survey or the Periodic Performance Review.

Q Which requirements in the “Management of Human
Resources” (HR) chapter apply for contracted staff?

A Contracted staff is subject to the same expectations for
qualifications, orientation, and competence assessment
as employed staff, regardless of whether the contractual
agreement is with an individual or an organization.
Specifically, standards HR.1.20, HR.2.10, HR.2.20,
HR.3.10, and HR.3.20 need to be met for contracted
staff. HR.1.20 addresses qualifications; HR.2.10 and
HR.2.20 address orientation, training, and education;
and HR.3.10 and HR.3.20 address competence assess-
ment and performance evaluations. Examples illustrat-
ing how to meet the HR requirements for contracted
staff are located on the Joint Commission’s Web site at
http://www.jointcommission.org/Standards/FAQs/.
Click on your accreditation manual’s link and reference
the “Management of Human Resources” section to
locate the “Human Resource Standards Applicability to
Contracted and Volunteer Personnel” link.

Q Does Standard LD.3.50 replace the credentialing and
privileging requirements for licensed independent practi-
tioners?

A No, Standard LD.3.50 does not replace the re-
quirements for credentialing and privileging (standards
MS.4.00 through MS.4.45 for hospitals and critical
access hospitals and Standards HR.4.10 through
HR.4.60 for ambulatory care, behavioral health
care, and long term care). When using a licensed
independent practitioner’s services through contractual
agreement, your organization retains the responsibil-
ity for meeting the credentialing and privileging require-
ments. There are exceptions in the case of telemedical
services and services provided off site—these excep-
tions are described in the introduction to Standard
LD.3.50.

Q Are the requirements for telemedical services the same as
for off-site services?

A No, the credentialing and privileging requirements are
covered at different EPs, as follows:
• Direct care through a telemedical link is addressed at
Standard MS.4.120, EP 1
• Interpretive services through a telemedical link (for
example, teleradiology) are addressed at Standard
LD.3.50, EP 9
• A footnote to EP 4 of Standard LD.3.50 applies
when patients are sent off site for care, treatment, or
services

Q If I contract with an organization that is accredited or
certified by the Joint Commission, do I have to comply
with Standard LD.3.50?

A Yes, oversight of contracted services is required,
regardless of whether the contractor is or is not
accredited or certified by the Joint Commission.

If you choose to contract with a Joint
Commission–accredited or –certified organization,
you should do the following:
1. Determine that the care, treatment, or services you
want them to provide on your behalf are included in
the scope of their accreditation or certification
AND
2. Ensure that their policies and practices meet your
requirements for staff qualifications and competence
and for providing care, treatment, and services

If both of these conditions are met, you can com-
ply with EP 6 of Standard LD.3.50 by periodically
reviewing the contractor’s accreditation or certification
status, including their performance on the standards
relevant to the scope of your contract. You can set and
evaluate additional performance expectations if you
wish, but a review of the accreditation or certification
status is sufficient to meet EP 6. Examples related to
contracting with a Joint Commission–accredited
organization are located on the Joint Commission’s
Web site at http://www.jointcommission.org/
Standards/FAQs/. Click on your accreditation manu-
al’s link and reference the “Management of Human
Resources” section to locate the “Human Resource
Standards Applicability to Contracted and Volunteer
Personnel” link.

If you choose to contract with an organization
that is not accredited or certified by the Joint
Commission, be aware that their policies or processes
may not meet the standards. Because their perfor-
ance may affect your organization’s accreditation, you
are encouraged to communicate with them about
Joint Commission requirements so that the contractor
knows how to comply with requirements for the care,
treatment, and services they provide on your behalf.

Continued on page 6
Approved: Revisions to Contracted Services Standard LD.3.50 (continued)

Continued from page 5

For More Information

Additional questions about Standard LD.3.50 should be directed to the Joint Commission’s Standards Interpretation Group through its online question form at http://www.jointcommission.org/Standards/OnlineQuestionForm, or by calling 630/792-5900.

Official Publication of Revised Standard

Revised Standard LD.3.50

APPLIES TO AMBULATORY CARE (AHC), BEHAVIORAL HEALTH CARE (BHC), CRITICAL ACCESS HOSPITAL (CAH), HOME CARE (OME), HOSPITAL (HAP), LABORATORY (LAB), LONG TERM CARE (LTC), MEDICARE/ MEDICAID-BASED LONG TERM CARE (LT2), AND OFFICE-BASED SURGERY (OBS)

Effective January 1, 2008

Leadership (LD)

Standard for Oversight of Care, Treatment, and Services Provided Through Contractual Agreement

(AHC, BHC, CAH, HAP, LAB, LTC, OME)

Introduction

The same level of high-quality care should be delivered to [patients] regardless of whether services are provided directly by the [organization] or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively. Standard LD.3.50 outlines the requirements for leadership oversight of care, treatment, and services provided through contractual agreement.

The only contractual agreements subject to the requirements in Standard LD.3.50 are those for the provision of care, treatment, and services provided to the [organization]’s [patients]. (OME: Such services would include any licensed professional service, personal care or support, pharmacy dispensing, clinical/consultant pharmacist, long term care pharmacy, ambulatory infusion, home medical equipment, clinical

Contractual agreement An agreement with any organization, group, agency, or individual for services or personnel to be provided by, to, or on behalf of the organization. Such agreements are defined in a contract or in some other form of written agreement such as a letter of agreement or memorandum of understanding (also referred to as contract, contracted services, contractual services, memorandum of understanding, letter of agreement, or written agreement).

respiratory, rehabilitation technology, and hospice services.) Any contract not for care, treatment, or services is not subject to this standard. For example, contracts for consultation or referrals are not subject to the requirements in LD.3.50. However, regardless of whether or not a contract is subject to LD.3.50, the actual performance of any contracted service is evaluated at the other standards in this manual appropriate to the nature of the contracted service.

Monitoring Contracted Services

The elements of performance require contracted services to be monitored, but they do not prescribe a specific monitoring strategy. While monitoring activities should focus on the safety and quality of the contracted service, the organization is free to select monitoring activities appropriate to the risk posed to [patients] by the contracted care, treatment, and services.

The expectations that leaders set for the performance of contracted services should reflect basic principles of risk reduction, safety, staff competence, and performance improvement. The requirements outlined in Standards EC.1.10, EC.1.20, PI.1.10, and HR.3.10 can provide ideas for setting expectations related to these topics. Additional ideas for expectations can also come from the elements of performance found in specific standards applicable to the contracted service. Although leaders have the same responsibility for oversight of contracted services outside the [organization]’s expertise as they do for contracted services within the [organization]’s expertise, it is more difficult to determine how to monitor such services. In these cases, information from relevant professional organizations can provide guidance for setting expectations. (BHC: Additionally, the [organization] may want to consider expectations related to responsiveness, communication, follow-up, or [patient] rights.)

The elements of performance do not prescribe the methods for evaluating contracted services; leaders are expected to select the best methods for their [organization] to oversee the quality and safety of services provided through contractual agreement. Some examples of sources of information that...
Revised Standard LD.3.50 (continued)

may be used for evaluating contracted services include the following:

- Review of information about the contractor’s Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including (AHC, CAH, HAP, LAB, LTC, OBS: medical) (BHC: clinical/case) (OME: patient) records
- Review of incident reports
- Review of periodic reports submitted by the individual or organization providing services under contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and from [patients]
- Review of [patient] satisfaction studies
- Review of results of risk management activities

In the event that contracted services do not meet expectations, leaders are expected to take steps to improve care, treatment, and services. In some cases, it may be best to work with the contractor to make improvements, whereas in other cases it may be best to renegotiate or terminate the contractual relationship. When the leaders anticipate the renegotiation or termination of a contractual agreement, planning needs to occur so that the continuity of care, treatment, and services is not disrupted.

Credentialing and Privileging
(AHC, BHC, CAH, HAP, LTC)

In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the [organization] using their services following the process described in the (CAH, HAP: Medical Staff) (AHC, BHC, LTC: Management of Human Resources) chapter. However, there (CAH, HAP: are three special circumstances) (AHC, BHC, LTC: is one special circumstance):

- (HAP, CAH: Direct care through a telemedical link: Standard MS.4.120, EP 1 describes several options for credentialing and privileging licensed independent practitioners who are responsible for the care, treatment, and services of the [patient] through a telemedical link).
- (HAP, CAH: Interpretive services through a telemedical link: Standard LD.3.50, EP 9 describes the circumstances under which a hospital can accept the credentialing and privileging decisions of a Joint Commission–accredited ambulatory care organization for licensed independent practitioners providing interpretive services through a telemedical link).
- Off-site services provided by a Joint Commission–accredited contractor: A footnote to EP.4 of Standard LD.3.50 outlines how an organization can expect a Joint Commission–accredited or –certified contractor to demonstrate the appropriate privileges of the licensed independent practitioners who will be providing [patient] care, treatment, and services have appropriate privileges. The options outlined in the footnote apply when patients are sent off site for services.

Standards for Oversight of Contracted Services
(OBS)

Introduction

The same level of high-quality care should be delivered to [patients] regardless of whether the services are provided directly by the organization or through contractual agreement. Requirements for the oversight of contracted services are found in Standard LD.3.50. The actual performance of contracted services is evaluated at the other standards in this manual. The practice leaders may choose to provide some services through contractual agreements, but they must still retain overall responsibility and authority for the level of safety and quality of the [patient] care provided. These services might include the following:

- Diagnostic radiology services
- Pathology and clinical laboratory services
- Pharmaceutical services
- Anesthesia services

[Moved to the introduction from the current rationale]

Standard LD.3.50

(AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME)

Care, treatment, and services provided through contractual agreement are provided safely and effectively.

Rationale for LD.3.50

(AHC, BHC, CAH, HAP, LAB, LTC, LT2, OME)

The guiding principle behind the requirements for contracted services is that the same level of high-quality care should be delivered regardless of whether services are provided directly by the organization or through contractual agreement. Just as leadership oversight is necessary to

2 A practice’s services include those provided by a central laboratory and any ancillary, near-patient-testing, hospital-based, and point-of-care laboratories.
make sure that services provided directly are safe and effective, leadership oversight of services provided through contractual agreement is required in order to assure that those services are provided safely and effectively.

Elements of Performance for LD.3.50

B 1. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS) Clinical leaders (CAH, HAP; and medical staff) have an opportunity to provide advice about the sources of clinical services that are to be provided through contractual agreement.

Previously EP 2

A 2. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME) The nature and scope of services provided through contractual agreements are described in (OME: a written agreement) (AHC, BHC, CAH, HAP, LAB, LTC, OBS: writing).  

Previously EPs 3 & 4 for Home Care; previously EP 4 for all other programs.

A 3. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME) Designated leaders approve the contractual agreements.

Previously EP 1

Leaders monitor contracted services by doing the following (EPs 4–6):

B 4. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME) Establishing expectations for the performance of the contracted services  

Replaces EP 6

B 5. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME) Communicating the expectations in writing to the provider of the contracted services

Replaces EP 6

B 6. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME) Evaluating the contracted services in relation to the expectations

Replaces EP 6

B 7. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME) Leaders take steps to improve contracted services that do not meet expectations.

A 8. (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS, OME) When contract agreements are renegotiated or terminated, the continuity of [patient] care is maintained.

A 9 27. (CAH, HAP) When using the services of licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for either direct care or interpretive services, the organization can accept the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider as long as only after confirming that those decisions are made using the process described in MS.4.10 through MS.4.20.

A 10 8 (AHC, BHC, CAH, HAP, LAB, LTC, LT2, OBS) Reference and contract lab services meet the applicable federal regulations for clinical laboratories and maintain evidence of the same.

Note:

- Home Care EPs 9 & 10 will be renumbered as 11 & 12.
- Critical Access Hospital EPs 21–26 will be renumbered as 23–28.

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1 LAB: A written agreement (such as a formal contract) is not required for reference laboratories; however, it is required for a contracted service where a major portion of laboratory testing is provided by an outside laboratory. Moved here from EP 8

4 AHC, BHC, CAH, HAP, LTC, LT2, OBS: When the organization contracts with another accredited organization for [patient] care, treatment, and services to be provided off site, it can do the following:

- Verify that all licensed independent practitioners who will be providing [patient] care, treatment, and services have appropriate privileges (AHC, CAH, HAP, LTC, LT2, OBS: privileges) (BHC: clinical responsibilities) by obtaining, for example, a copy of the list of (AHC, CAH, HAP, LTC, LT2, OBS: privileges) (BHC: clinical responsibilities)

or

- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges (AHC, CAH, HAP, LTC, LT2, OBS: privileges) (BHC: clinical responsibilities).

A written description of the expectations can be provided either as part of the written agreement or in addition to it.

This EP does not prescribe the steps to take when contracted services do not meet expectations. Some examples to consider include the following:

- Increase monitoring of the contracted services
- Provide consultation or training to the contractor
- Renegotiate the contract terms
- Apply defined penalties
- Terminate the contract
The 2008 National Patient Safety Goals and Requirements (continued)

Continued from page 1

• The development of a one-year phase-in period for the two new requirements mentioned above (3E and 16A). The Joint Commission will not expect full implementation of the new requirements in 2008, but has outlined specific expectations for planning, development, and testing “milestones” at three, six, and nine months in 2008. Full implementation is expected by the beginning of 2009. (See pages 13–14 and 19 for the full text of these implementation expectations.)

• The addition of Requirement 2C, addressing timely reporting of critical test results, for the long term care and Medicare/Medicaid certification-based long term care programs. This is an existing requirement for all other programs. (See pages 11–12.)

• The retirement of requirement 3B as a National Patient Safety Goal for all programs, addressing limiting and standardizing drug concentrations. However, this requirement will remain as an element of performance under “Medication Management” (MM) standard MM.2.20.*

• The modification of requirement 7A on hand hygiene guidelines for all programs, to allow use of the World Health Organization Hand Hygiene Guidelines as an alternative to the Centers for Disease Control and Prevention Guidelines. (See page 15.)

The Joint Commission assesses compliance with these requirements throughout the accreditation cycle through on-site surveys and by the accredited organization in its Periodic Performance Review (PPR).* For each of the National Patient Safety Goal requirements, an organization either complies or does not comply with the requirement, or the requirement does not apply to the organization.

When an organization does not fully comply with a requirement, the organization will be assigned a requirement for improvement (RFI) in the same way that non-compliance with a standard generates an RFI. All RFIs must be addressed in an Evidence of Standards Compliance (ESC) report. Failure to resolve an RFI affects an organization’s accreditation decision, which could ultimately lead to a loss of accreditation.

As with Joint Commission standards, accredited organizations are expected to be continuously compliant with the requirements associated with the National Patient Safety Goals. The Joint Commission provides guidance on how to achieve effective compliance with each goal’s requirements. This guidance includes detailed answers to Frequently Asked Questions (FAQs), which are posted on the Joint Commission Web site at http://www.jointcommission.org/Standards/NationalPatientSafetyGoals.

The Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™ contains a related set of requirements that apply to ambulatory care, critical access hospital, disease-specific care, hospital, and office-based surgery programs. The complete Universal Protocol and its Guidelines for Implementation are provided in the box on pages 19–22.


A note about implementation expectations: Each of the National Patient Safety Goals includes a set of implementation expectations. These implementation expectations are preceded by the letter “A,” or “C,” and may also be preceded by the symbol “☐”. The letters “A” and “C” (designating scoring categories) and the measure of success (MOS) symbol “☐” are components of the scoring system. For detailed information on the elements of the scoring system, please see the “How to Use This Manual” chapter of your accreditation or certification manual.

* Note: Organizations providing pediatric and/or neonatal acute care services that have received Joint Commission approval of a Request for Review of an Alternative Approach to National Patient Safety Goal 3B to participate in a planned transition from dosing methods using customized drug concentrations (for example, the “Rule of 6”) to the required standardized concentrations may continue their planned transition process, which must be completed by the end of 2008.

1 For organizations required to submit a PPR.

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Abbreviation Key:
Applies to Ambulatory Care (AHC), Assisted Living Facilities (ALF), Behavioral Health Care (BHC), Critical Access Hospital (CAH), Disease-Specific Care (DSC), Home Care (OME), Hospital (HAP), Integrated Delivery Systems (IDS), Laboratory (LAB), Long Term Care (LTC), Managed Care Organizations (MCO), Medicare/Medicaid-Based Long Term Care (LT2), Office-Based Surgery (OBS), and Preferred Provider Organizations (PPO)

2008 National Patient Safety Goals

Note: New language is indicated in underline; deleted text is shown in strikethrough.

Note: Gaps in the numbering indicate that a Goal or requirement was “retired,” usually because the requirements were integrated into the standards.

Goal 1
Improve the accuracy of [patient] identification.
(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

Requirement 1A (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)
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

A 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Two [patient] identifiers are used when administering medications (AHC, ALF, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME: or blood products).

A 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Two [patient] identifiers are used when collecting blood samples and other specimens for clinical testing.

A 3. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Two [patient] identifiers are used when providing other treatments or procedures.

A 4. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The [patient’s] room number or physical location is not used as an identifier.

A 5. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Containers used for blood and other specimens are labeled in the presence of the [patient].

A 6. (LAB) Processes are established to maintain a sample’s identity throughout the pre-analytical, analytical, and post-analytical processes.

Requirement 1B (ALF, LAB, LTC, LT2, OME)
Prior to the start of any (ALF, LTC, LT2, OME: surgical or invasive procedure, conduct a final verification process (such as a “time-out”) to confirm the correct [patient], procedure and site, using active—not passive—communication techniques.

Implementation Expectations for Requirement 1B

A 1. (ALF, LAB, LTC, LT2, OME) The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

A 2. (ALF, LAB, LTC, LT2, OME) The process must involve the entire team, use active communication, and must, at least, include the following:
   - Correct [patient] identity
   - Correct side and site (LAB: and availability of appropriate documents)
   - Agreement on the procedure to be done
   - Correct [patient] position
   - Availability of correct implants and any special equipment or special requirements

A 3. (ALF, LAB, LTC, LT2, OME) The process is briefly documented, such as in a checklist.

Note: The organizations should determine the type and amount of documentation.
2008 National Patient Safety Goals (continued)

Implementation Expectations for Requirement 2B
A 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization develops a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

A 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The list of abbreviations not to be used includes the following:
- U.u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d., qod
- Trailing zero (X.0 mg)*
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

Implementation Expectations for Requirement 2C
A 1. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization defines critical tests and critical results and values.

A 2. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization defines the acceptable length of time between the ordering of critical tests and reporting the critical tests and critical results and values.

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### 2008 National Patient Safety Goals (continued)

A 3. **(AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** The organization defines the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed caregiver.

A 4. **(AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** The organization collects data on the timeliness of reporting critical tests and critical results and values.

A 5. **(AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** The organization assesses the data and determines whether there is a need for improvement.

A 6. **(AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** The organization takes appropriate action to improve and measure the effectiveness of those actions.

☐ C 7. **(LAB)** Critically abnormal results are communicated quickly to a responsible individual so that prompt action may be taken.

A 8. **(LAB)** When the responsible licensed caregiver is not available, a back-up reporting system can ensure the information is provided in a timely manner to another qualified responsible caregiver to prevent avoidable delays in treatment or response.

**Requirement 2E (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)**

Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

**Rationale for Requirement 2E**

The primary objective of a “handoff” is to provide accurate information about a patient’s care, treatment, and services, current condition and any recent or anticipated changes. The information communicated during a handoff must be accurate in order to meet patient safety goals.

**AHC, ALF, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME:** In health care there are numerous types of patient handoffs, including but not limited to nursing shift changes; physicians transferring complete responsibility for a patient; physicians transferring on-call responsibility; temporary responsibility for staff leaving the unit for a short time; **(AHC, ALF, CAH, DSC, HAP, LAB, OBS, OME):** anesthesiologist report to post-anesthesia recovery room nurse; **(LAB):** nursing and physician handoff from the emergency department to inpatient units, different hospitals, nursing homes, and home health care; and critical laboratory and radiology results sent to physician offices.

**BHC:** In Behavioral Health organizations that provide twenty-four-hour care, treatment, or services, a number of handoffs may occur, such as from teacher to child care worker, at change of shift, or from clinical staff to program staff.

**Implementation Expectations (IEs) for Requirement 2E**

The organization’s process for effective “handoff” communication includes the following (IEs 1–4):

1. ☐ C 1. **(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** Interactive communications allowing for the opportunity for questioning between the giver and receiver of patient information.

2. ☐ C 2. **(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** Up-to-date information regarding the patient’s care, treatment and services, condition and any recent or anticipated changes.

3. ☐ C 3. **(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** A process for verification of the received information, including repeat-back or read-back, as appropriate.

4. A 4. **(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** An opportunity for the receiver of the handoff information to review relevant patient historical data, which may include previous care, treatment, and services.

5. ☐ C 5. **(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)** Interruptions during handoffs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

**Goal 3**

**Improve the safety of using medications.** **(AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)**

**Requirement 3B (AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)**

Standardize and limit the number of drug concentrations used by the organization.
Rationale for Requirement 3B
When medications are part of the [patient] treatment plan, appropriate management is critical to ensuring [patient] safety. The development of standardized and redundant systems has been shown to decrease errors and improve outcomes.

Implementation Expectations for Requirement 3B
A 1. (AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) Standardize the drug concentrations used by the organization.

A 2. (AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) When more than one concentration of a drug is necessary, the number of concentrations are limited to the minimum required to meet [patient] care needs.

Requirement 3C (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME)
Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.

Implementation Expectations for Requirement 3C
A 1. (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME) Identify a list of look-alike/sound-alike (LASA) drugs used by the organization (the list must include a minimum of 10 LASA drug combinations selected from the tables of LASA drugs posted on the Joint Commission Web site).

A 2. (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME) Review the list of look-alike/sound-alike drugs used by the organization at least annually.

A 3. (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME) The organization takes action to prevent errors involving the interchange of these drugs.

Requirement 3D (AHC, CAH, HAP, OBS)
Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

Implementation Expectations for Requirement 3D
A 1. (AHC, CAH, HAP, OBS) Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.

A 2. (AHC, CAH, HAP, OBS) Labeling occurs when any medication or solution is transferred from the original packaging to another container.

A 3. (AHC, CAH, HAP, OBS) Labels include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.

C 4. (AHC, CAH, HAP, OBS) All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

A 5. (AHC, CAH, HAP, OBS) No more than one medication or solution is labeled at one time.

A 6. (AHC, CAH, HAP, OBS) Any medications or solutions found unlabeled are immediately discarded.

C 7. (AHC, CAH, HAP, OBS) All original containers from medications or solutions remain available for reference in the perioperative/procedural area until the conclusion of the procedure.

A 8. (AHC, CAH, HAP, OBS) All labeled containers on the sterile field are discarded at the conclusion of the procedure.

C 9. (AHC, CAH, HAP, OBS) At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.

Rationale for Requirement 3E
This risk reduction activity is consistent with safe medication practices and addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings.

Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. Medications or other solutions in unlabeled containers are unidentifiable. This unsafe practice neglects basic principles of medication management safety yet has been routine in many organizations with respect to medications transferred to the sterile field.

Implementation Expectations for Requirement 3E
A 1. (AHC, HAP, CAH, LTC, OBS, OME) Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

Note: This requirement applies only to organizations that provide anticoagulation therapy.

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2008 National Patient Safety Goals (continued)

Rationale for Requirement 3E
Anticoagulation is a high-risk treatment that commonly leads to adverse drug events due to the complexity of dosing anticoagulation medications, monitoring their effects, and ensuring patient compliance with outpatient therapy. The use of standardized practices that include patient involvement can reduce the risk of adverse drug events associated with the use of heparin (unfractionated), low molecular weight heparin (LMWH), warfarin, and other anticoagulants.

Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing (“milestones”) at 3, 6, and 9 months in 2008, with the expectation of full implementation by January 1, 2009.

Implementation Expectations for Requirement 3E
A 1. (AHC, HAP, CAH, LTC, OBS, OME) As of April 1, 2008, the [organization]’s leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of Requirement 3E.

A 2. (AHC, HAP, CAH, LTC, OBS, OME) As of July 1, 2008, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of Requirement 3E by January 1, 2009.

A 3. (AHC, HAP, CAH, LTC, OBS, OME) As of October 1, 2008, pilot testing of the process in at least one clinical unit is under way.

A 4. (AHC, HAP, CAH, LTC, OBS, OME) As of January 1, 2009, the process is fully implemented across the organization.

The Implementation Expectations (IEs) that will apply beginning January 1, 2009, are provided below (IEs 1–11).

Implementation Expectations for 3E
A 1. (AHC, HAP, CAH, LTC, OBS, OME) The organization implements a defined anticoagulant management program to individualize the care provided to each patient receiving anticoagulant therapy.

A 2. (AHC, HAP, CAH, LTC, OBS, OME) To reduce compounding and labeling errors, the organization uses ONLY oral unit dose products and pre-mixed infusions when these products are available.

Goal 7
Reduce the risk of health care–associated infections.
(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)
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Rationale for Requirement 7A
Compliance with the WHO Hand Hygiene Guidelines or CDC hand hygiene guidelines will reduce the transmission of infectious agents by staff to [patients], thereby decreasing the incidence of health care–associated infections.

Implementation Expectation for Requirement 7A
\( \text{C} \) 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Comply with current WHO Hand Hygiene Guidelines or CDC hand hygiene guidelines* (BHC: when providing services to a high-risk population or administering physical care).

Requirement 7B (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)
Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care–associated infection.

Rationale for Requirement 7B
A significant percentage of [patients] who unexpectedly die or suffer major permanent loss of function have health care–associated infections. These unanticipated deaths and injuries meet the definition of a sentinel event and, therefore, are required to undergo a root cause analysis. The root cause analysis should attempt to answer the questions (1) why did the [patient] acquire an infection and, (2) given the fact of the infection, why did the [patient] die or suffer permanent loss of function?

Implementation Expectations Requirement 7B
\( \text{C} \) 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization manages all identified cases of unanticipated death or major permanent loss of function associated with a health care–associated infection as sentinel events (that is, conducts a root cause analysis).

\( \text{A} \) 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The root cause analysis addresses the management of the [patient] before and after the identification of infection.

Goal 8
Accurately and completely reconcile medications across the continuum of care. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)

Requirement 8A (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)
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 most at risk during transitions in care (handoffs) across settings, services, providers, or levels of care. The development, reconciliation and communication of an accurate medication list throughout the continuum of care is essential in the reduction of transition-related adverse drug events.

Implementation Expectations for Requirement 8A
\( \text{C} \) 1. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The organization, with the [patient’s] involvement, creates a complete list of the [patient’s] current medications at admission/entry.

\( \text{C} \) 2. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The medications ordered for, administered to, or dispensed to the [patient] while under the care of the organization are compared to those on the list and any discrepancies (for example, omissions, duplications, potential interactions) are resolved.

Requirement 8B (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)
A complete list of the [patient’s] medications is communicated to the next provider of service when a [patient] is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the organization.

Implementation Expectations for Requirement 8B
\( \text{C} \) 1. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The [patient’s] accurate medication reconciliation list (complete with medications prescribed by the first provider of service) is communicated to the next provider of service, whether it be within or outside the organization.

* Organizations are required to comply with all 1A, 1B, and 1C CDC or WHO guidelines.
The 2008 National Patient Safety Goals (continued)

Goal 9
Reduce the risk of [patient] harm resulting from falls.
(ALF, CAH, DSC, HAP, LTC, LT2, OME)

Requirement 9B (ALF, CAH, DSC, HAP, LTC, LT2, OME)
Implement a fall reduction program including an evaluation of the effectiveness of the program.

Rationale for Requirement 9B
Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate each [patient’s] risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening, walking aids, assistive technologies and protective devices assessment, and environmental assessments.

Implementation Expectations for Requirement 9B
A 1. (ALF, CAH, DSC, HAP, LTC, LT2, OME) The organization establishes a fall reduction program.

A 6. (ALF, CAH, DSC, HAP, LTC, LT2, OME) The fall reduction program is evaluated to determine the effectiveness of the program.

Note: Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.

Goal 10
Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
(ALF, DSC, LTC, LT2)

Requirement 10A (ALF, DSC, LTC, LT2)
Develop and implement a protocol for administration and documentation of the flu vaccine.

Rationale for Requirement 10A
Influenza and pneumonia combined represent the fifth leading cause of death in the elderly. Along with the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), the Joint Commission promotes the administration of influenza and pneumococcal vaccines to adult residents in long term care and assisted living facilities and disease-specific care programs.

Implementation Expectations for Requirement 10A
A 1. (ALF, DSC, LTC, LT2) Appropriate protocols are developed to determine whether or not to administer the flu vaccine to a [patient].

C 2. (ALF, DSC, LTC, LT2) There is evidence that protocols were implemented for residents identified as high risk.

Requirement 10B (ALF, DSC, LTC, LT2)
Develop and implement a protocol for administration and documentation of the pneumococcus vaccine.

Implementation Expectations for Requirement 10B
A 1. (ALF, DSC, LTC, LT2) Appropriate protocols are developed to determine whether or not to administer the pneumococcus vaccine to a [patient].

C 2. (ALF, DSC, LTC, LT2) There is evidence that protocols were implemented for [patients] identified as high risk.
2008 National Patient Safety Goals (continued)

Requirement 10C (ALF, DSC, LTC, LT2)
Develop and implement a protocol to identify new cases of influenza and to manage an outbreak.

Implementation Expectations for Requirement 10C
A 1. (ALF, DSC, LTC, LT2) Protocols are developed to identify cases of influenza and to manage an outbreak.
C 2. (ALF, DSC, LTC, LT2) There is evidence the protocols were followed for [patients] displaying signs and symptoms of influenza.
A 3. (ALF, DSC, LTC, LT2) There is evidence the outbreak was managed (or identified) and tracked.

Goal 11
Reduce the risk of surgical fires.
(AHC, OBS)

Requirement 11A (AHC, OBS)
Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels with enough time for [patient] preparation, and establish guidelines to minimize oxygen concentration under drapes.

Rationale for Requirement 11A
When surgical fires occur, they often result in serious injury and sometimes death. The unique circumstances in the surgical environment (oxygen-rich atmosphere, flammable materials, and ignition sources) require response and prevention strategies to be specific to the setting. Educating surgical staff to these distinctions is crucial in reducing/eliminating surgical fires.

Implementation Expectations for Requirement 11A
A 1. (AHC, OBS) Organizations assess the risk for surgical fires based on equipment and procedures used.
A 2. (AHC, OBS) The organization establishes guidelines to minimize oxygen concentrations under drapes.
C 3. (AHC, OBS) Organizations that identify themselves at risk provide staff training on methods to minimize oxygen concentration under drapes.
C 4. (AHC, OBS) Organizations that identify themselves at risk provide staff training on methods to avoid the use of flammable solutions and materials.
C 5. (AHC, OBS) Organizations that identify themselves at risk provide staff training on actions to take in the event of a surgical fire.

Goal 12
Implementation of applicable National Patient Safety Goals and associated requirements by components and practitioner sites.
(IDS, MCO, PPO)

Requirement 12A (IDS, MCO, PPO)
Inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements.

Implementation Expectation for Requirement 12A
C 1. (IDS, MCO, PPO) Organizations inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements.

Goal 13
Encourage [patients]’ active involvement in their own care as a [patient] safety strategy.
(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

Requirement 13A (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)
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 Expectations for Requirement 13A
C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) [Patients] and families are educated on methods available to report concerns related to care, treatment, services, and [patient] safety issues.
C 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization encourages [patient]s and their families to report concerns about safety.

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The 2008 National Patient Safety Goals and Requirements (continued)

Goal 14
Prevent health care–associated pressure ulcers (decubitus ulcers).
(LTC, LT2)

Requirement 14A (LTC, LT2)
Assess and periodically reassess each [patient]’s risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks.

Rationale for Requirement 14A
Pressure ulcers (decubiti) continue to be problematic in all health care settings. Estimates are that 1.3 to 3 million adults have a pressure ulcer. The cost of treatment is $500 to $40,000 per ulcer. The incidence of pressure ulcer is from 2.2% to 23.9% in long term care and 0% to 17% in home care. Most pressure ulcers can be prevented and deterioration at Stage I can be halted. The use of clinical practice guidelines can effectively identify [patients] and define early intervention for prevention of pressure ulcers.

Implementation Expectations for Requirement 14A
A 1. (LTC, LT2) There is a plan for the prediction, prevention, and early treatment of pressure ulcers, which addresses:
   • Identifying individuals at risk and the specific factors placing them at risk.
   • Maintaining and improving tissue tolerance to pressure in order to prevent injury.
   • Protecting against the adverse effects of external mechanical forces.
   • Reducing the incidence of pressure ulcers through staff education programs.

C 2. (LTC, LT2) Initial assessments are performed at admission.

C 3. (LTC, LT2) A systematic risk assessment is conducted using a validated risk assessment tool such as the Braden Scale or Norton Scale.

C 4. (LTC, LT2) Pressure ulcer risk is reassessed at periodic intervals.

C 5. (LTC, LT2) Action is taken to address any identified risks.

Goal 15
The organization identifies safety risks inherent in its [patient] population.
(BHC, HAP, OME)

Rationale for Goal 15 (BHC, HAP, OME)
Probabilistic risk assessment has been used to assess the designs of high-hazard systems such as chemical engineering plants and space initiatives. Probabilistic risk assessment looks at events that contributed to adverse outcomes. Health care has the ability to identify those areas of high-risk potential based on previous sentinel events and other data.

Requirement 15A (BHC, HAP)
The organization identifies [patients] at risk for suicide.
   (HAP: Note: This requirement only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.)

Rationale for Requirement 15A
Suicide ranks as the eleventh most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #1 most frequently reported type of sentinel event since the inception of the Joint Commission’s Sentinel Event Policy in 1996. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important first step in protecting and planning the care of these at-risk individuals.

Implementation Expectations for Requirement 15A
C 1. (BHC, HAP) The risk assessment includes identification of specific factors and features that may increase or decrease risk for suicide.

C 2. (BHC, HAP) The [patient]’s immediate safety needs and most appropriate setting for treatment are addressed.

C 3. (BHC, HAP) The organization provides information such as a crisis hotline to individuals and their family members for crisis situations.

Requirement 15B (OME)
The organization identifies risks associated with long-term oxygen therapy such as home fires.

Rationale for Requirement 15B
Nearly 43 percent of all sentinel events reported by home
2008 National Patient Safety Goals (continued)

care programs to the Joint Commission were due to a fire in
the [patient]'s home. Since April 1997, 11 sentinel events
were received and reviewed by the Joint Commission related
to home health care [patients] who were either injured or
killed as a result of a fire in the home. In each case home
oxygen was in use.

Implementation Expectations for Requirement 15B
C 1. (OME) The home safety risk assessment includes
presence or absence and working order of smoke detectors,
fire extinguishers and fire safety plans, and review of all
medical equipment.

C 2. (OME) The organization provides education to the
[patient] and family regarding causes of fire and fire preven-
tion activities.

C 3. (OME) The organization assesses the [patient]'s level
of comprehension and compliance and reports any concerns
to the [patient]'s physician.

Goal 16
Improve recognition and response to
to changes in a patient's condition.
(CAH, HAP)

Requirement 16A (CAH, HAP)
The organization selects a suitable method that enables
health care staff members to directly request additional
assistance from a specially trained individual(s) when the
patient’s condition appears to be worsening.

Rationale for Requirement 16A
A significant number of critical inpatient events are preceded
by warning signs for an average of 6 to 8 hours. Critical
events such as cardiopulmonary and respiratory arrests or
changes in patient’s vital signs are estimated to occur in
4% to 17% of inpatient admissions. Early response by a
specially trained individual(s) to changes in a patient’s con-
dition may reduce cardiopulmonary arrests and patient
mortality.

Note: This requirement has a one-year phase-in peri-

dination of the development, testing, and implementation of
Requirement 16A.

A 2. (CAH, HAP) As of July 1, 2008, an implementation work
plan is in place that identifies adequate resources, assigned
accountabilities, and a time line for full implementation of
Requirement 16A by January 1, 2009.

A 3. (CAH, HAP) As of October 1, 2008, pilot testing of the
process in at least one clinical unit is under way.

A 4. (CAH, HAP) As of January 1, 2009, the process is fully
implemented across the organization.

The Implementation Expectations (IEs) that will
apply beginning January 1, 2009, are provided
below (IEs 1–6).

Implementation Expectations for Requirement 16A

A 1. (CAH, HAP) The organization selects an early recogni-
tion and response method most suitable for its needs and
resources.

A 2. (CAH, HAP) The organization develops criteria for call-
ing additional assistance to respond to a change in patient’s
condition or perception of change by the staff, patients, and
families.

A 3. (CAH, HAP) The organization empowers staff, patients,
and families to request additional assistance when they have
a concern about the patient’s condition.

C 4. (CAH, HAP) Formal education for urgent response
policies and practices is conducted with the people who may
request assistance and the people who may respond to
those requests.

A 5. (CAH, HAP) The organization measures the utility and
effectiveness of the intervention(s) employed.

A 6. (CAH, HAP) The organization measures cardiopul-
monary arrest, respiratory arrest, and mortality rates before
and after implementation of an early intervention plan.

Universal Protocol
(AHC, CAH, DSC, HAP, OBS)
Wrong site, wrong procedure, wrong person surgery can be
prevented. This universal protocol is intended to achieve that
goal. It is based on the consensus of experts from the rele-

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endorsed by more than 40 professional medical associations and organizations.

In developing this protocol, consensus was reached on the following principles:

- Wrong site, wrong procedure, wrong person surgery can and must be prevented.
- A robust approach—using multiple, complementary strategies—is necessary to achieve the goal of eliminating wrong site, wrong procedure, wrong person surgery.
- Active involvement and effective communication among all members of the surgical team is important for success.
- To the extent possible, the patient (or legally designated representative) should be involved in the process.
- Consistent implementation of a standardized approach using a universal, consensus-based protocol will be most effective.
- The protocol should be flexible enough to allow for implementation with appropriate adaptation when required to meet specific patient needs.
- A requirement for site marking should focus on cases involving right/left distinction, multiple structures (fingers, toes), or levels (spine).
- The universal protocol should be applicable or adaptable to all operative and other invasive procedures that expose patients to harm, including procedures done in settings other than the operating room.

In concert with these principles, the following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, wrong person surgery:

1. Pre-operative verification process
   - **Purpose:** To ensure that all the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient’s expectations and with the team’s understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.
   - **Process:** An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the “time-out” just before the start of the procedure.

2. Marking the operative site
   - **Purpose:** To identify unambiguously the intended site of incision or insertion.
   - **Process:** For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.

3. “Time-out” immediately before starting the procedure
   - **Purpose:** To conduct a final verification of the correct patient, procedure, site, and, as applicable, implants.
   - **Process:** Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a “fail-safe” mode, that is, the procedure is not started until any questions or concerns are resolved.

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**Universal Protocol 1**

The organization fulfills the expectations set forth in the Universal Protocol.

(AHC, CAH, DSC, HAP, OBS)

**UP Requirement 1A (AHC, CAH, DSC, HAP, OBS)**

Conduct a pre-operative verification process as described in the Universal Protocol.

**Implementation Expectations for UP Requirement 1A**

1. **A 1. (AHC, CAH, DSC, HAP, OBS)** Verification of the correct person, procedure, and site should occur during the following (as applicable):
   - At the time the surgery/procedure is scheduled
   - At the time of admission or entry into the facility
   - Anytime the responsibility for care of the patient is transferred to another caregiver
   - With the patient involved, awake and aware, if possible
   - Before the patient leaves the preoperative area or enters the procedure/surgical room

2. **A 2. (AHC, CAH, DSC, HAP, OBS)** The following is reviewed prior to the start of the procedure:
   - Relevant documentation (for example, history and physical, consent)
• Relevant images, properly labeled and displayed
• Any required implants and special equipment

UP Requirement 1B (AHC, CAH, DSC, HAP, OBS)
Mark the operative site as described in the Universal Protocol.

Implementation Expectations for UP Requirement 1B

C 1. (AHC, CAH, DSC, HAP, OBS) Make the mark at or near the incision site; do not mark any non-operative site(s) unless necessary for some other aspect of care.

A 2. (AHC, CAH, DSC, HAP, OBS) The mark must be unambiguous.

Note: For example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous.

C 3. (AHC, CAH, DSC, HAP, OBS) The mark must be positioned to be visible after the patient is prepped and draped.

A 4. (AHC, CAH, DSC, HAP, OBS) The method of marking and type of mark should be consistent throughout the organization.

C 5. (AHC, CAH, DSC, HAP, OBS) At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.

C 6. (AHC, CAH, DSC, HAP, OBS) The person performing the procedure should do the site marking.

C 7. (AHC, CAH, DSC, HAP, OBS) Marking must take place with the patient involved, awake and aware, if possible.

UP Requirement 1C (AHC, CAH, DSC, HAP, OBS)
Conduct a “time-out” immediately before starting the procedure as described in the Universal Protocol.

Implementation Expectations for UP Requirement 1C

C 1. (AHC, CAH, DSC, HAP, OBS) The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

A 2. (AHC, CAH, DSC, HAP, OBS) The process must involve the entire operative team, use active communication, and must, at least, include the following:

• Correct [patient] identity
• Correct side and site
• Agreement on the procedure to be done
• Correct [patient] position
• Availability of correct implants and any special equipment or special requirements

C 3. (AHC, CAH, DSC, HAP, OBS) The process is briefly documented, such as in a checklist.

Note: The organization should determine the type and amount of documentation.

A 4. (AHC, CAH, DSC, HAP, OBS) The organization should have processes and systems in place for reconciling differences in staff responses during the final verification process.

Guidelines for the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™ (AHC, CAH, DSC, HAP, OBS)
These guidelines provide detailed implementation requirements, exemptions and adaptations for special situations.

1. Pre-operative verification process
Verification of the correct person, procedure, and site should occur (as applicable):

• At the time the surgery/procedure is scheduled
• At the time of admission or entry into the facility
• Anytime the responsibility for care of the patient is transferred to another caregiver
• With the patient involved, awake and aware, if possible
• Before the patient leaves the preoperative area or enters the procedure/surgical room

A preoperative verification checklist may be helpful to ensure availability and review of the following, prior to the start of the procedure:

• Relevant documentation (for example, history and physical, consent)
• Relevant images, properly labeled and displayed
• Any required implants and special equipment

2. Marking the operative site

• Make the mark at or near the incision site. Do NOT mark any non-operative site(s) unless necessary for some other aspect of care.
• The mark must be unambiguous (for example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous).

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2008 National Patient Safety Goals (continued)

- The mark must be positioned to be visible after the patient is prepped and draped.
- The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.
- The method of marking and type of mark should be consistent throughout the organization.
- At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).
  
  **Note:** In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.

- The person performing the procedure should do the site marking.
- Marking must take place with the patient involved, awake and aware, if possible.
- Final verification of the site mark must take place during the “time-out.”
- A defined procedure must be in place for patients who refuse site marking.

**Exemptions:**

- Single organ cases (for example, Cesarean section, cardiac surgery)
- Interventional cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization)
- Teeth—BUT, indicate operative tooth name(s) on documentation OR mark the operative tooth (teeth) on the dental radiographs or dental diagram
- Premature infants, for whom the mark may cause a permanent tattoo

3. **“Time-out” immediately before starting the procedure**

   Must be conducted in the location where the procedure will be done, just before starting the procedure. It must involve the entire operative team, use active communication, be briefly documented, such as in a checklist (the organization should determine the type and amount of documentation) and must, at the least, include the following:

   - Correct patient identity
   - Correct side and site
   - Agreement on the procedure to be done
   - Correct patient position
   - Availability of correct implants and any special equipment or special requirements

   The organization should have processes and systems in place for reconciling differences in staff responses during the “time-out.”

4. **Procedures for non-OR settings including bedside procedures**

   - Site marking must be done for any procedure that involves laterality, multiple structures or levels (even if the procedure takes place outside of an OR).
   - Verification, site marking, and “time-out” procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.
   - Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through the conduct of the procedure may be exempted from the site marking requirement. The requirement for a “time-out” final verification still applies.
Effective January 1, 2008, all Health Care Staffing Services (HCSS) organizations certified by The Joint Commission will be required to uniformly adopt a set of three Stage II (standardized) performance measures to meet the requirements for certification. The standardized measures contained in the final set reflect modifications and revisions made to the candidate measures following a six-month pilot test and subsequent recommendations from the Health Care Staffing Services Performance Measure Expert Panel. The final measure set includes the following:

- Do Not Return Rate for Clinical Reasons
- Do Not Return Rate for Professional Reasons
- Personnel File Audit

Detailed information about the Stage II HCSS measure set will be provided in the Health Care Staffing Services Performance Measure Implementation Guide, 2nd Edition. The revised edition can be accessed at http://www.jointcommission.org/CertificationPrograms/HealthCareStaffingServices/pm_hcs in late July 2007. These Stage II measures will replace the Stage I measures currently in use by HCSS firms for performance improvement.

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