International Patient Safety Goals (IPSG)

Overview

This chapter addresses the International Patient Safety Goals (IPSG), as required for implementation as of 1 January 2011 in all organizations accredited by Joint Commission International (JCI) under the International Standards for Hospitals.

The purpose of the IPSG is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence- and expert-based consensus solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high-quality health care, the goals generally focus on system-wide solutions, wherever possible.

The goals are structured in the same manner as the other standards, including a standard (goal statement), an intent statement, and measurable elements. The goals are scored similar to other standards as "met," "partially met," or "not met." The accreditation decision rules include compliance with the IPSG as a separate decision rule.

Note: Some standards require the hospital to have a written policy, procedure, program, or other written document for specific processes. Those standards are indicated by a Ⓟ icon after the standard text.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Goal 1: Identify Patients Correctly

IPSG.1 The hospital develops and implements a process to improve accuracy of patient identifications. Ⓟ

Goal 2: Improve Effective Communication

IPSG.2 The hospital develops and implements a process to improve the effectiveness of verbal and/or telephone communication among caregivers. Ⓟ

IPSG.2.1 The hospital develops and implements a process for reporting critical results of diagnostic tests. Ⓟ

IPSG.2.2 The hospital develops and implements a process for handover communication. Ⓟ

Goal 3: Improve the Safety of High-Alert Medications

IPSG.3 The hospital develops and implements a process to improve the safety of high-alert medications. Ⓟ

IPSG.3.1 The hospital develops and implements a process to manage the safe use of concentrated electrolytes. Ⓟ

Goal 4: Ensure Safe Surgery

IPSG.4 The hospital develops and implements a process for the preoperative verification and surgical/invasive procedure site-marking. Ⓟ

IPSG.4.1 The hospital develops and implements a process for the time-out that is performed immediately prior to the start of the surgical/invasive procedure and the sign out that is conducted after the procedure. Ⓟ

Goal 5: Reduce the Risk of Health Care-Associated Infections

IPSG.5 The hospital adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health care–associated infections. Ⓟ

Goal 6: Reduce the Risk of Patient Harm Resulting from Falls

IPSG.6 The hospital develops and implements a process to reduce the risk of patient harm resulting from falls for the inpatient population. Ⓟ

IPSG.6.1 The hospital develops and implements a process to reduce the risk of patient harm resulting from falls for the outpatient population. Ⓟ

Goals, Standards, Intents, and Measurable Elements

Goal 1: Identify Patients Correctly

Standard IPSG.1

The hospital develops and implements a process to improve accuracy of patient identifications. Ⓟ

Intent of IPSG.1

Wrong-patient errors occur in virtually all aspects of diagnosis and treatment.[1] Patients may be sedated, disoriented, not fully alert, or comatose; may change beds, rooms, or locations within the hospital; may have sensory disabilities; may not remember their identity; or may be subject to other situations that may lead to errors in correct identification. The intent of this goal is twofold: 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. (*Also see* MMU.4.1)

The identification process used throughout the hospital requires at least two ways in which to identify a *patient*, such as the patient's name, identification number, birth date, a bar-coded wristband, or other ways. (*Also see* MOI.9, ME 2 and MOI.9.1, ME 1) The patient's room number or location in the hospital cannot be used for identification. The *process* for using two different patient identifiers is uniform throughout the hospital. However, the two identifiers used in the inpatient department may be different from the two identifiers in the outpatient department. **For example**, the patient's name and identification number or medical record number may be used in all inpatient areas, and the patient name and birth date may be used in all outpatient departments, such as the emergency department, *ambulatory care* department, or other outpatient location.

There are special circumstances in which the hospital may need to develop a specific process for patient identification; **for example**, when a comatose or confused/disoriented patient arrives with no identification, in the case of a newborn when the parents have not immediately chosen a name, and other examples. The process takes into account the unique needs of the patients, and staff use the process for patient identification in these special circumstances to prevent error.[2]

Two different patient identifiers are required in any circumstance involving patient interventions. **For example**, patients are identified before providing treatments (such as administering medications, blood, or

blood products; serving a restricted diet tray; or providing radiation therapy); performing procedures (such as insertion of an intravenous line or hemodialysis); and before any diagnostic procedures (such as taking blood and other specimens for clinical testing, or performing a cardiac catheterization or diagnostic radiology procedure).

Measurable Elements of IPSG.1

- ❑ 1. Patients are identified using two patient identifiers, not including the use of the patient's room number and location in the hospital. (*Also see* MMU.5.2, ME 4 and MOI.9, ME 2)
- ❑ 2. Patients are identified before performing diagnostic procedures, providing treatments, and performing other procedures. (*Also see* IPSG.4.1; AOP.5.7, ME 2; MMU.5.2, ME 4; and MMU.6.1)
- ❑ 3. The hospital ensures the correct identification of patients in special circumstances, such as the comatose patient or newborn who is not immediately named. (*Also see* COP.3)

Goal 2: Improve Effective Communication

Standard IPSG.2

The hospital develops and implements a process to improve the effectiveness of verbal and/or telephone communication among caregivers. Ⓟ

Standard IPSG.2.1

The hospital develops and implements a process for reporting critical results of diagnostic tests. Ⓟ

Standard IPSG.2.2

The hospital develops and implements a process for handover communication. Ⓟ

Intent of IPSG.2 Through IPSG.2.2

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. Patient care circumstances that can be critically impacted by poor communication include verbal and telephone patient care orders, verbal and telephone communication of critical test results, and handover communications.

Patient care orders given verbally in-person and over the telephone, if permitted under local laws and regulations, are some of the most error-prone communications. Different accents, dialects, and pronunciations can make it difficult for the receiver to understand the order being given. **For example**, drug names and numbers that sound alike, such as erythromycin and azithromycin or fifteen and fifty, can affect the accuracy of the order. Background noise, interruptions, and unfamiliar drug names and terminology often compound the problem. Once received, a verbal order must be transcribed as a written order, which adds complexity and risk to the ordering process. (*Also see* COP.2.2 and MMU.4, ME 1)

The reporting of critical results of diagnostic tests is also a patient safety issue. Diagnostic tests include, but are not limited to, laboratory tests, radiology exams, nuclear medicine exams, ultrasound procedures, magnetic resonance imaging, and cardiac diagnostics. This includes critical results from any diagnostic tests performed at the bedside, such as point-of-care testing, portable radiographs, bedside ultrasounds, or transesophageal echocardiograms. Results that are significantly outside the normal range may indicate a high-risk or life-threatening condition. A formal reporting system that clearly identifies how critical results of diagnostic tests

are communicated to health care practitioners and how the information is documented reduces patient risks.[3–5] (*Also see* AOP.5.4)

Handover communications can also be referred to as *handoff* communications. Handovers of patient care within a hospital occur

- between *health care practitioners* (**for example**, physician to physician, physician to nurse, nurse to nurse, and so on);
- between different levels of care in the same hospital (**for example**, when the patient is moved from an intensive care unit to a medical unit or from an emergency department to the operating theatre);
- from inpatient units to diagnostic or other treatment departments, such as radiology or physical therapy; and
- between staff and patients/families, such as at discharge. (*Also see* ACC.4.1)

Breakdowns in communication can occur during any handover of patient care and can result in *adverse events*.[6–8] Interruptions and other distractions from unit activities can inhibit clear communication of important patient information. Standardized, critical content for communication between the patient, family, caregiver, and health care practitioners can significantly improve the outcomes related to handovers of patient care.[9–14] (*Also see* ACC.3)

Standardized forms, tools, or methods support a consistent and complete handover process. The content of the handover communication and the form, tool, or method used is standardized for the type of handover. The handover process may be different for different types of handovers within the hospital. **For example**, handovers of patient care for the emergency department to a medical ward may require a different process or different content than handovers for the operating theatre to the intensive care unit; however, the handovers are standardized for the type of handover occurring. Handover forms or tools, if used by the hospital, are not required to be part of the medical record. In addition, the detailed information communicated during the handover is not required to be documented in the medical record; however, the hospital may want to have documentation that the handover occurred. **For example**, the health care practitioner would record that he or she completed the handover and to whom he or she endorsed care, and then sign, date, and time the entry. (*Also see* MOI.11.1, MEs 1, 2, and 3)

Safe practices for effective communication include the following:

- Limiting verbal communication of prescription or medication orders to urgent situations in which immediate written or electronic communication is not feasible. **For example**, verbal orders can be disallowed when the prescriber is present and the patient's chart is available. Verbal orders can be restricted to situations in which it is difficult or impossible for hard-copy or electronic order transmission, such as during a sterile procedure.
- The development of guidelines for requesting and receiving test results on an emergency or STAT basis, the identification and definitions of critical tests and critical values, to whom and by whom critical test results are reported, and monitoring compliance (*Also see* AOP.5.1.1, ME 3)
- Writing down, or entering into a computer, the complete order or test result by the receiver of the information; the receiver reading back the order or test result; and the sender confirming that what has been written down and read back is accurate. Permissible alternatives for when the read-back process may not always be possible may be identified, such as in the operating theatre and in emergent situations in the emergency department or intensive care unit. (*Also see* COP.2.2; MMU.4)
- Use of standardized, critical content for communication between the patient, family, health care practitioner, and others involved in the patient's care during handovers of patient care.
- Use of standardized methods, forms, or tools to facilitate consistent and complete handovers of patient care

Measurable Elements of IPSG.2

❑ 1. The complete verbal order is documented and read back by the receiver and confirmed by the individual giving the order. (*Also see* MMU.4.1)

❑ 2. The complete telephone order is documented and read back by the receiver and confirmed by the individual giving the order. (*Also see* MMU.4.1)

❑ 3. The complete test result is documented and read back by the receiver and confirmed by the individual giving the result.

Measurable Elements of IPSG.2.1

❑ 1. The hospital has defined critical values for each type of diagnostic test.

❑ 2. The hospital has identified by whom and to whom critical results of diagnostic tests are reported.

❑ 3. The hospital has identified what information is documented in the medical record.

Measurable Elements of IPSG.2.2

❑ 1. Standardized critical content is communicated between health care practitioners during handovers of patient care.

❑ 2. Standardized forms, tools, or methods support a consistent and complete handover process.

❑ 3. Data from adverse events resulting from handover communications are tracked and used to identify ways in which handovers can be improved, and improvements are implemented.

Goal 3: Improve the Safety of High-Alert Medications

Standard IPSG.3

The hospital develops and implements a process to improve the safety of high-alert medications. Ⓟ

Standard IPSG.3.1

The hospital develops and implements a process to manage the safe use of concentrated electrolytes. Ⓟ

Intent of IPSG.3 and IPSG.3.1

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. Any medication, even those that can be purchased without a prescription, if used improperly can cause injury. However, high-alert medications cause harm more frequently, and the harm they produce is likely to be more serious when they are given in error. This can lead to increased patient suffering and potentially additional costs associated with caring for these patients. *High-alert medications* are those medications involved in a high percentage of errors and/or sentinel events, as well as medications that carry a higher risk for abuse or other adverse outcomes. **Examples** of high-alert medications include investigational medications, controlled medications, medications with a narrow therapeutic range, chemotherapy, anticoagulants, psychotherapeutic medications, and look-alike/sound-alike medications (LASA).

There are many medication names that sound or look like other medication names. Confusing names is a common cause of medication errors throughout the world. Contributing to this confusion are

- incomplete knowledge of drug names;
- newly available products;
- similar packaging or labeling;
- similar clinical use; and
- illegible prescriptions or misunderstanding during issuing of verbal orders.

Examples of lists of high-alert medications are available from organizations such as the Institute for Safe Medication Practices (ISMP) and the World Health Organization (WHO). For safe management, the

hospital needs to develop its own list(s) of high-alert medications based on its unique utilization patterns of medications and its own internal data about near misses, medication errors, and sentinel events. (*Also see* MMU.7.1 and QPS.7) The list includes medications identified as high risk for adverse outcomes. Information from the literature and/or Ministry of Health may also be useful in helping to identify which medications should be included. These medications are stored in a way that reduces the likelihood of inadvertent administration or ideally provides directions on the proper use of the medication. Strategies to improve the safety of high-alert medications may be tailored to the specific risk of each medication and should include consideration of prescribing, preparation, administration, and monitoring processes, in addition to safe storage strategies.

Medications at risk for look-alike/sound-alike confusion, such as similar medication names and similar product packaging, may lead to potentially harmful medication errors. Hospitals need to institute risk management strategies to minimize adverse events with LASA medications and enhance patient safety. (*Also see* MMU.4.1)

A frequently cited medication safety issue is the incorrect or unintentional administration of concentrated electrolytes (**for example**, potassium chloride [equal to or greater than 2 mEq/mL concentration], potassium phosphate [equal to or greater than 3 mmol/mL concentration], sodium chloride [greater than 0.9% concentration], and magnesium sulfate [equal to or greater than 50% concentration]). The most effective means to reduce or to eliminate these occurrences is to develop a process for managing concentrated electrolytes that includes removing the concentrated electrolytes from the patient care units to the pharmacy. (*Also see* MMU.3) The hospital identifies any areas where concentrated electrolytes are clinically necessary in the concentrated form as determined by evidence and professional practice, such as the intensive care unit or cardiac operating theatre, and identifies how they are clearly labeled and how they are stored in those areas in a manner that restricts access to prevent inadvertent administration.

Measurable Elements of IPSG.3

- ❑ 1. The hospital identifies in writing its list of high-alert medications and develops and implements a process for managing these high-alert medications.
- ❑ 2. The hospital has a list of look-alike/sound-alike medications and develops and implements a process for managing look-alike sound-alike medications.
- ❑ 3. The process for managing high-alert medications and the process for managing look-alike/sound-alike medications are uniform throughout the hospital.

Measurable Elements of IPSG.3.1

- ❑ 1. The hospital has a process that prevents inadvertent administration of concentrated electrolytes.
- ❑ 2. Concentrated electrolytes are present only in patient care units identified as clinically necessary in the concentrated form. (*Also see* MMU.5.2, ME 2)
- ❑ 3. Concentrated electrolytes that are stored in patient care units are clearly labeled and stored in a manner that restricts access and promotes safe use.

Goal 4: Ensure Safe Surgery

Standard IPSG.4

The hospital develops and implements a process for the preoperative verification and surgical/invasive procedure site-marking. Ⓟ

Standard IPSG.4.1

The hospital develops and implements a process for the time-out that is performed immediately prior to the start of the surgical/invasive procedure and the sign-out that is conducted after the procedure. Ⓟ

Intent of IPSG.4 and IPSG.4.1

Significant patient injury and adverse and sentinel events resulting from wrong-site, wrong-procedure, and wrong-patient surgery are ongoing concerns for hospitals. Such events can result from ineffective or inadequate communication between members of the team conducting the *surgical/invasive procedure*, lack of a process for marking the procedure site, and lack of patient involvement in the site marking. In addition, inadequate patient assessment, inadequate medical record review, a culture that does not support open communication among team members, problems related to illegible handwriting, and the use of abbreviations are frequent contributing factors.

Surgical and invasive procedures include all procedures involving an incision or puncture, including, but not limited to, open surgical procedures, percutaneous aspiration, selected injections, biopsy, percutaneous cardiac and vascular diagnostic or interventional procedures, laparoscopies, and endoscopies.

Organizations need to identify all areas within the hospital where surgical and invasive procedures take place; **for example**, the cardiac catheterization lab, interventional radiology department, gastrointestinal lab, and the like. The approach the hospital takes to ensuring safe surgery applies to all areas of the hospital in which surgical and invasive procedures occur.

The (US) Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™ is based in part on the principle of using multiple strategies to achieve the goal of always identifying the correct patient, correct procedure, and correct site.[25] The essential elements of the Universal Protocol are

- the preoperative verification process;
- marking the surgical site; and
- the time-out that is held immediately before the start of the procedure.

Preoperative Verification Process

Preoperative verification is an ongoing process of information gathering and confirmation. The purpose of the preoperative verification process is to

- verify the correct patient, procedure, and site;
- ensure that all relevant documents, images, and studies are available, properly labeled, and displayed; and
- verify that any required blood products, special medical equipment, and/or implants are present. (*Also see* ASC.7.4)

There are various elements of the preoperative verification process that can be completed before the patient arrives at the preoperative area—such as ensuring that documents, imaging, test results, and paperwork are properly labeled and match the patient's identifiers. Waiting until the time-out to complete the preoperative verification process may unnecessarily delay surgery if paperwork or imaging are not labeled or available when surgery is about to begin. It is more likely that portions of the preoperative verification may occur more than once and in more than one place. **For example**, the surgical consent may be obtained in the surgeon's office, and then verification that it has been completed may take place in the preoperative holding area.

Marking the Site

Marking the surgical/invasive site involves the patient and is done with an instantly recognizable and unambiguous mark. Ideally, an "X" is not used as the mark as it may be interpreted as "not here" or "wrong side" and could potentially lead to errors in patient care.[26,27] The mark must be consistent throughout the hospital. The site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

The surgical/invasive procedure site marking is done by the person who will perform the procedure. This person will do the entire surgical/invasive procedure and remain with the patient throughout the entire procedure. In cases of surgical procedures, the *responsible surgeon* typically performs the surgery and therefore would mark the site. There are different titles used for the responsible surgeon, such as attending or consultant surgeon. For nonsurgical invasive procedures, it may be a physician who will do the procedure, and it may take place in an area of the hospital outside of the operating theatre.

There are circumstances when a *trainee* may perform the site marking—this is when the trainee performs the entire procedure, requiring minimal or no supervision from the responsible surgeon or physician. In these circumstances, the trainee marks the surgical site. When a trainee is in the role of assisting the responsible surgeon or physician, only the responsible surgeon or physician may perform the site marking.

The site marking may take place any time before the surgical/invasive procedure begins as long as the patient is actively involved in the site marking whenever possible and the mark is visible after the patient is prepped and draped. **Examples** of when patient participation may not be possible include patients who are not competent to make health care decisions, children, and patients requiring emergent surgery.

Time-Out

The time-out is held immediately before the start of the procedure with all team members present. During the time-out, the team agrees on the following components:

a) Correct patient identity
b) Correct procedure to be done
c) Correct surgical/invasive procedure site

The time-out allows any unanswered questions or confusion to be resolved. The time-out is conducted in the location at which the procedure will be done and involves the active participation of the entire team. The patient does not have to participate in the time-out. Once the time-out is complete, no one from the team leaves the room. Completion of the time-out is documented and includes the date and time the time-out was completed. The hospital determines the amount and type of any additional documentation.

Sign-Out

The WHO Surgical Safety Checklist includes a sign-out process, which is conducted in the area where the procedure was performed before the patient leaves.[28] The following components of the sign-out are verbally confirmed by a member of the team, typically a nurse:

d) Name of the surgical/invasive procedure that was recorded/written
e) Completion of instrument, sponge, and needle counts (as applicable)
f) Labeling of specimens (when specimens are present during the sign-out process, labels are read aloud, including patient name) (*Also see* IPSG.1, ME 2 and AOP.5.7, ME 2)
g) Any equipment problems to be addressed (as applicable)

Measurable Elements of IPSG.4

❑ 1. The hospital implements a preoperative verification process through the use of a checklist or other mechanism to document, before the surgical/invasive procedure, that the informed consent is appropriate to the procedure; that the correct patient, correct procedure, and correct site are verified; and that all required documents, blood products, medical equipment, and implantable medical devices are on hand, correct, and functional.

❑ 2. The hospital uses an instantly recognizable and unambiguous mark for identifying the surgical/invasive site that is consistent throughout the hospital.

❑ 3. Surgical/invasive site marking is done by the person performing the procedure and involves the patient in the marking process.

Measurable Elements of IPSG.4.1

- ❑ 1. The full team actively participates in a time-out process, which includes a) through c) in the intent, in the area in which the surgical/invasive procedure will be performed, immediately before starting the procedure. Completion of the time-out is documented. (*Also see* MOI.11.1)
- ❑ 2. Before the patient leaves the area in which the surgical/invasive procedure was performed, a sign-out process is conducted, which includes at least d) through g) in the intent.
- ❑ 3. When surgical/invasive procedures are performed, including medical and dental procedures done in settings other than the operating theatre, the hospital uses uniform processes to ensure safe surgery.

Goal 5: Reduce the Risk of Health Care–Associated Infections

Standard IPSG.5

The hospital adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health care–associated infections. Ⓟ

Intent of IPSG.5

Infection prevention and control are challenging in most health care settings, and rising rates of health care–associated infections are a major concern for patients and health care practitioners. Infections common to all health care settings include catheter-associated urinary tract infections, bloodstream infections, and pneumonia (often associated with mechanical ventilation).

Central to the elimination of these and other infections is proper hand hygiene. Evidence-based hand-hygiene guidelines are available from the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (US CDC), and various other national and international organizations.[29,30] (*Also see* GLD.11.2)

The hospital adopts and implements current evidence-based hand-hygiene guidelines. Hand-hygiene guidelines are posted in appropriate areas, and staff are educated in proper hand-washing and hand-disinfection procedures. Soap, disinfectants, and towels or other means of drying are located in those areas where hand-washing and hand-disinfecting procedures are required. (*Also see* PCI.9)

Measurable Elements of IPSG.5

- ❑ 1. The hospital has adopted current evidence-based hand-hygiene guidelines.
- ❑ 2. The hospital implements a hand-hygiene program throughout the hospital.
- ❑ 3. Hand-washing and hand-disinfection procedures are used in accordance with hand-hygiene guidelines throughout the hospital. (*Also see* IPSG.9, ME 4)

Goal 6: Reduce the Risk of Patient Harm Resulting from Falls

Standard IPSG.6

The hospital develops and implements a process to reduce the risk of patient harm resulting from falls for the inpatient population. Ⓟ

Standard IPSG.6.1

The hospital develops and implements a process to reduce the risk of patient harm resulting from falls for the outpatient population. Ⓟ

Intent of IPSG.6 and IPSG.6.1

Many injuries in hospitals to both inpatients and outpatients are a result of falls. The risk for falls is related to the patient, the situation, and/or the location. Risks associated with patients might include patient history of falls, medications use, alcohol consumption, gait or balance disturbances, visual impairments, altered mental status, and the like. Patients who have been initially assessed to be at low risk for falls may suddenly become at high risk. Reasons include, but are not limited to, surgery and/or anesthesia, sudden changes in patient condition, and adjustment in medications. Many patients require reassessment during their hospitalization. (*Also see* AOP.1.4)

Fall risk criteria identify the types of patients who are considered at high risk for falls. These criteria and any interventions applied are documented in the patient's medical record as they provide the evidence to support the patient's fall risk category. The hospital has the responsibility to identify the types of patients within their patient population who may be at high risk for falls. The documented criteria facilitate the continuity of care among the health care practitioners caring for a patient. (*Also see* ACC.3) **For example**, a practitioner caring for a patient after he or she leaves the operating theatre may not know if the patient, who is at high risk for falls was properly assessed and if interventions were applied unless proper documentation was completed.

In the context of the populations it serves, the services it provides, and its facilities, the hospital evaluates patient falls, and takes action to reduce the risk of falling and reduce the risk of injury should a fall occur. The hospital establishes a fall-risk reduction program based on appropriate policies and/or procedures. A fall reduction program includes risk assessment and periodic reassessment of a particular patient population and/or of the environment in which care and services are provided (such as those conducted during periodic safety tours). Measures and interventions are implemented to reduce fall risk for those identified patients, situations, and locations assessed to be at risk.[31–33]

Specific situations can pose a risk for falls. **An example** of a potential situational risk is when a patient arrives at the outpatient department from a long term care facility by ambulance for a radiologic examination. The patient may be at risk for falls in that situation when transferring from ambulance cart to exam table, or when changing positions while lying on the narrow exam table.

Specific locations may present higher fall risks because of the services provided. **For example**, a physical therapy department (inpatient or outpatient) has many types of specialized equipment used by patients that may increase the risk for falls, such as parallel bars, freestanding staircases, and exercise equipment.

All inpatients are assessed for fall risk using assessment tools and/or methods appropriate for the hospital's patient population(s).[34,35] **For example**, pediatric patients require a pediatric fall risk assessment tool, as a tool developed for adults will not accurately assess their risk for falls.

In the outpatient department(s), patients are screened for fall risk; however, only those patients whose condition, diagnosis, situation, and/or location identifies them as at risk for falls are screened.[36,37] If fall risk

is indicated from the screening, measures and/or interventions are implemented to reduce fall risk for those patients.

Screening generally involves performing a simple evaluation of the patient to determine if he or she exhibits a fall risk. Screening tools are commonly used, and include questions or items that are used to identify fall risk patients. **For example**, the questions may require a simple yes/no answer, or the tool may involve assigning a score to each item based on the patient's responses.

The hospital determines which outpatients are screened for fall risk. Location and situational risk as well as patient condition and characteristics may help identify those who should be screened for falls. **Examples** could include all patients in a physical therapy outpatient department, all patients arriving from long term care facilities by ambulance for outpatient procedures, patients scheduled for outpatient surgery involving procedural sedation or anesthesia, patients with gait or balance disturbances, patients with visual impairments, pediatric patients under the age of two, and so on.

Measurable Elements of IPSG.6

- ❑ 1. The hospital implements a process for assessing all inpatients for fall risk and uses assessment tools/methods appropriate for the patients being served.
- ❑ 2. The hospital implements a process for the reassessment of inpatients who may become at risk for falls due to a change in condition, or are already at risk for falls based on the documented assessment.
- ❑ 3. Measures and/or interventions to reduce fall risk are implemented for those identified inpatients, situations, and locations within the hospital assessed to be at risk. Patient interventions are documented.

Measurable Elements of IPSG.6.1

- ❑ 1. The hospital implements a process for screening outpatients whose condition, diagnosis, situation, or location may put them at risk for falls and uses screening tools/methods appropriate for the patients being served.
- ❑ 2. When fall risk is identified from the screening process, measures and/or interventions are implemented to reduce fall risk for those outpatients identified to be at risk, and the screening and interventions are documented.
- ❑ 3. Measures and/or interventions to reduce fall risk are implemented in situations and locations in the outpatient department(s) assessed to be a risk for falls.

References

1. ECRI Institute. ECRI Institute PSO Deep Dive. Patient identification: Executive summary. Aug 2016. Accessed Nov 11, 2016. https://www.ecri.org/Pages/Patient-Identification-Deep-Dive.aspx.
2. The Joint Commission. Temporary names put newborns at risk. *Jt Quick Safety.* 2015 Oct;17:1–2. Accessed Nov 11, 2016. https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_17_Oct_2015_10_20_15.pdf.
3. Mosallam R, Ibrahim SZ. Critical value reporting at Egyptian laboratories. *J Patient Saf.* Epub 2015 Jun 12.
4. Roy CL, et al. An initiative to improve the management of clinically significant test results in a large health care network. *Jt Comm J Qual Patient Saf.* 2013 Nov;39(11):517–527.
5. Yang D, Zhou Y, Yang C. Analysis of laboratory repeat critical values at a large tertiary teaching hospital in China. *PLoS One.* 2013;8(3):e59518.
6. Andersen HB, et al. Development and validation of a taxonomy of adverse handover events in hospital settings. *Cogn Technol Work.* 2015 Feb;17(1):79–87.
7. Smaggus A, Weinerman AS. Handover: The fragile lines of communication. *Canadian Journal of General Internal Medicine.* 2015;10(4):15–19.
8. Smith CJ, et al. Interunit handoffs from emergency department to inpatient care: A cross-sectional survey of physicians at a university medical center. *J Hosp Med.* 2015 Nov;10(11):711–717.

9. Agency for Healthcare Research and Quality (AHRQ). Strategy 3: Nurse bedside shift report. In *Guide to Patient and Family Engagement in Hospital Quality and Safety.* Rockville, MD: AHRQ, 2013. Accessed Nov 9, 2016. http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy3/index.html.
10. Craig R, et al. Strengthening handover communication in pediatric cardiac intensive care. *Paediatr Anaesth.* 2012 Apr;22(4):393–399.
11. Drachsler H, et al. The Handover Toolbox: A knowledge exchange and training platform for improving patient care. *BMJ Qual Saf.* 2012 Dec;21 Suppl 1:i114–120.
12. Johnson M, Jefferies D, Nicholls D. Developing a minimum data set for electronic nursing handover. *J Clin Nurs.* 2012 Feb;21(3–4):331–343.
13. Segall N, et al. Can we make postoperative patient handovers safer? A systematic review of the literature. *Anesth Analg.* 2012 Jul;115(1):102–115.
14. Starmer AJ, et al. Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident handoff bundle. *JAMA.* 2013 Dec 4;310(21):2262–2270.
15. Institute for Safe Medication Practices. Medication Safety Tools and Resources. 2016. Accessed Nov 13, 2016. https://www.ismp.org/tools/.
16. Khoo AL, et al. A multicenter, multidisciplinary, high-alert medication collaborative to improve patient safety: The Singapore experience. *Jt Comm J Qual Patient Saf.* 2013 May;39(5):205–212.
17. Shaw KN, et al.; Pediatric Emergency Care Applied Research Network. Reported medication events in a paediatric emergency research network: Sharing to improve patient safety. *Emerg Med J.* Epub 2012 Oct 31.
18. Agency for Healthcare Research and Quality Patient Safety Network. Patient Safety Primer: Medication Errors. 2015. (Updated: Mar 2015.) Accessed Nov 14, 2016. https://psnet.ahrq.gov/primers/primer/23/medication-errors.
19. Ching JM, et al. Using Lean to improve medication administration safety: In search of the "perfect dose." *Jt Comm J Qual Patient Saf.* 2013 May;39(5):195–204.
20. DeHenau C, et al. Tallman lettering as a strategy for differentiation in look-alike, sound-alike drug names: The role of familiarity in differentiating drug doppelgangers. *Appl Ergon.* 2016;52:77-84.
21. Institute for Healthcare Improvement (IHI). *How-to Guide: Prevent Harm from High-Alert Medications.* Cambridge, MA: IHI, 2012. Accessed Nov 14, 2016. http://www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventHarmfromHighAlertMedications.aspx.
22. Irwin A, et al. The effect of proximity, tall man lettering, and time pressure on accurate visual perception of drug names. *Hum Factors.* 2013 Apr;55(2):253–266.
23. Or CK, Wang H. A comparison of the effects of different typographical methods on the recognizability of printed drug names. *Drug Saf.* 2014 May;37(5):351–359.
24. Ostini R, et al. Quality use of medicines—Medication safety issues in naming; look-alike, sound-alike medicine names. *Int J Pharm Pract.* 2012 Dec;20(6):349–357.
25. The Joint Commission. National Patient Safety Goals Effective January 1, 2016: Hospital Accreditation Program. 2016. Accessed November 12, 2016. https://www.jointcommission.org/assets/1/6/2016_NPSG_HAP.pdf
26. American College of Obstetricians and Gynecologists. Patient safety in the surgical environment. Committee Opinion No. 464. *Obstet Gynecol.* 2010 Sep (Reaffirmed 2014);116:786–790.
27. Chabloz C, et al. Performance of correct procedure at correct body site: Correct site surgery. *Guide to Surgical Site Marking High 5s.* 2012 Oct:1–24.
28. World Health Organization. *Surgical Safety Checklist.* 2008. Accessed Nov 14, 2016. http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf?ua=1.
29. Centers for Disease Control and Prevention. Hand Hygiene in Healthcare Settings. 2016. Accessed Nov 14, 2016. https://www.cdc.gov/handhygiene/.
30. World Health Organization. Clean Care Is Safer Care. The Evidence for Clean Hands. (Updated: Apr 28, 2016.) Accessed Nov 14, 2016. http://www.who.int/gpsc/country_work/en/.
31. Agency for Healthcare Research and Quality. *Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care.* Rockville, MD: Agency for Healthcare Research and Quality, 2013. Accessed Nov 14, 2016. http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html.
32. Boushon B, et al. *How-to Guide: Reducing Patient Injuries from Falls.* Cambridge, MA: Institute for Healthcare Improvement, 2014. Accessed November 25, 2016. http://www.ihi.org/resources/Pages/Tools/TCABHowToGuideReducingPatientInjuriesfromFalls.aspx
33. Miake-Lye IM, et al. Inpatient fall prevention programs as a patient safety strategy: A systematic review. *Ann Intern Med.* 2013 Mar 5;158(5 Pt 2):390–396.
34. Heafner L, et al. Development of a tool to assess risk for falls in women in hospital obstetric units. *Nurs Womens Health.* 2013 Apr–May;17(2):98–107.

35. Lee J, Geller AI, Strasser DC. Analytical review: Focus on fall screening assessments. *PM R.* 2013 Jul;5(7):609–621.

36. Fielding SJ, McKay M, Hyrkas K. Testing the reliability of the Fall Risk Screening Tool in an elderly ambulatory population. *J Nurs Manag.* 2013 Nov;21(8):1008–1015.

37. Wu TY, et al. Risk factors for single and recurrent falls: A prospective study of falls in community dwelling seniors without cognitive impairment. *Prev Med.* 2013 Nov;57(5):511-517.