QM.18.1 There is a process implemented to prevent wrong patient, wrong site, and wrong surgery/procedure during all invasive interventions performed in operating rooms or other locations.

QM.18.2 The process consists of three phases: verification, site marking, and time out.

QM.18.3 A pre-procedure verification of the patient information is carried out including the patient's identity, consent, full details of the procedure, laboratory tests and images, and any implant or prosthesis.

QM.18.4 The surgical/procedural site is marked before conducting the surgery/procedure.

QM.18.4.1 The site is marked especially in bilateral organs and multiple structures (e.g. fingers, toes, and spine).

QM.18.4.2 The site is marked by the individual who will perform the procedure.

QM.18.4.3 The patient is involved in the marking process.

QM.18.4.4 The marking method is consistent throughout the hospital.

QM.18.4.5 The mark is visible after the patient is prepped and draped.

QM.18.5 A final check (time-out) is conducted before the procedure is initiated.

QM.18.5.1 The time-out is conducted in the location where the procedure will be done, just before starting.

QM.18.5.2 The time-out is initiated by a designated member of the team and involves the members of the team, including the individual performing the procedure, the anesthesia providers, and the nurse(s) involved.

QM.18.5.3 The entire procedure team uses active communication during the time out.

QM.18.5.4 During the time-out, the team members agree on the correct patient identity, the correct procedure to be performed, the correct site, and when applicable, the availability of the correct implant or equipment.

QM.18.6 The hospital documents its processes for preventing wrong patient, wrong site, and wrong surgery/procedure.

Standard Intent:

Preventing medical errors is an essential component of patient safety and surgery is an area of health care in which preventable medical errors and near misses can occur. Clinicians must be aware of the surgery-associated injuries, deaths, and near misses and the process to prevent them.

An important aspect in this regard is the process to prevent wrong-site surgery, which encompasses surgery performed on the wrong side or site of the body, a wrong surgical procedure performed, and surgery performed on the wrong patient. This process also includes "any invasive procedure performed in settings other than the operating room.

Hence, all health care facilities should develop and implement policy and procedure to include the three phases of this process (verification, site marking, and time out.) and to ensure its timely documentation in the patient medical record.

QM.19 The hospital ensures availability and safety of infusion pumps.

QM.19.1 Infusion pumps are available with adequate numbers throughout patient care areas.

QM.19.2 Infusion pumps have "free-flow" protection.

QM.19.3 Infusion pumps have documented preventative maintenance, inspection and testing on a regular basis.

Standard Intent:

To assure that fluids and medication are administered in a controlled manner so that all infusions are set to be infused in the ordered prescribed time, infusion pumps should be utilized.

For efficacy and patient safety reasons, a timeframe that infusions are administered is very important to be adhered to. Some infusions need to be given in a very short time while others need to be given over a long period of time.

All healthcare institutions should ensure that there is an adequate infusion pump available in every patient care unit. The available pumps should have the safety function of “free-flow” protection. (Anti-free-flow devices prevent blood from draining from the patient, or infuscate from freely entering the patient when the infusion pump is being set up).

All infusion pumps should have documented regular preventative maintenance, inspection, and testing.

QM.20 The hospital ensures the safety of the alarm systems of patient care equipment.

QM.20.1 All alarm systems for patient care equipment (such as infusion pumps and monitors) have documented preventative maintenance, inspection and testing on a regular basis.

QM.20.2 All staff are trained on the safe use of alarm systems for patient care equipment and the use of appropriate settings for sound.

Standard Intent:

Alarms on clinical devices are intended to call the attention of healthcare providers to patient or device conditions that deviate from a predetermined normal status. These alarms are generally considered to be a key tool in improving the safety of patients. Therefore, from the design perspective alarms should be easy to set, their status (e.g. on/off, limit values) should be easily determined if not directly visible, and the identification of and specificity of a triggered alarm should be clear and easy to determine.

From the user perspective, users must be adequately trained on the safe use of alarm systems for patient care equipment and the use of appropriate settings for sound.

All alarm systems should have documented regular preventative maintenance,