The organization must identify tests that may have critical results and educate clinical staff on what these tests are and how to recognize a critical result.

The organization implements a protocol that describes how critical results are recognized, documented, and communicated to the provider responsible for the patient's care, and the time frames for reporting and responding to critical results, including documenting of actions taken when applicable. This should include how to proceed when the individual performing the test is also the individual responsible for interpreting and responding to the test; for example, when a cardiologist performs and interprets the 12-lead electrocardiogram on the patient they are treating, or when the practitioner who performs the test is the same practitioner who is treating the patient. In these cases, the reporting of a critical result would not be necessary.

In addition to clearly identifying how results are communicated and the required time frame for doing so, the organization must implement a protocol that describes how the treating practitioner is expected to respond and in what time frame. The hospital must then monitor compliance with the above protocols and time frames for critical results and act when negative trends are observed, or adverse events occur. For example, keeping a log in the lab to document times that critical results are reported and that includes patient identifiers and names of staff who received the report is one way to simplify monitoring for compliance.

Measurable Elements of IPSG.02.00

1. Ⓓ The hospital defines, in writing, critical test results that may represent urgent or emergent life-threatening values for diagnostic tests. (*See also* AOP.03.02, ME 3)
2. Ⓓ The hospital develops a formal reporting process that identifies how critical results of diagnostic tests are reported/communicated to health care practitioners and the expected time frame for reporting the critical results.
3. The hospital identifies what critical result information is documented in the medical record.
4. Ⓓ The hospital monitors compliance with the defined time frames for reporting and acting on critical results, and documents actions taken when time frames are not met.

Standard IPSG.02.01

The hospital implements a standardized process for handover communication.

Intent of IPSG.02.01

Breakdowns in communication can occur during any handover of patient care and can result in patient safety events. *Handover* communications can also be referred to as *handoff* communications. Handovers of patient care within a hospital occur in the following ways:

- Between health care practitioners (for example, physician to physician, physician to nurse, nurse to nurse)
- 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
- Between staff and patients/families, such as at discharge

Interruptions and other distractions from unit activities can inhibit clear communication of important patient information. Standardized, critical content and processes for communication between the patient, family, caregiver, and health care team can significantly improve the outcomes related to handovers of patient care.

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 are 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 from the operating theatre to the intensive care unit; however, the handovers are standardized for the type of handover occurring.

Safe practices for effective communication include the following:

- Use of standardized, critical content and processes 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
- The handover process must allow for the participants to have an opportunity to clarify information during the handover process, by providing the opportunity to ask questions, or for discussion between the giver and the receiver of information. However, it is acceptable for the discussion to take place outside of in-person interactions, such as by phone, text, or other communication format.

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 they completed the handover and to whom they transferred responsibility for care, and then sign, date, and time the entry.

Measurable Elements of IPSG.02.01

1. The hospital implements a standardized procedure to communicate critical information between health care practitioners during handovers of patient care.
2. The hospital uses standardized forms, tools, or methods that support a consistent and complete handover process that includes the opportunity for all staff involved to clarify information and ask questions.
3. Ⓓ The hospital collects, analyzes, tracks, and trends data for patient safety events related to handovers.

Goal 3: Improve the Safety of Medications

Standard IPSG.03.00

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

Intent of IPSG.03.00

High-alert medication errors can lead to patient injury or death and potentially additional costs associated with caring for these patients. The Institute for Safe Medication Practices (ISMP) defines *high-alert medications* as "drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients." The most frequently cited examples of high-alert medications include the following:

- Insulin
- Opioids
- Chemotherapeutic agents
- Antithrombotic agents
- Anticoagulants
- Thrombolytics
- Medications with a narrow therapeutic range (for example, digitalis)
- Neuromuscular blocking agents
- Epidural or intrathecal medications