Being able to identify changes to policies, procedures, and programs is essential to maintain efficiency, effectiveness, and staff compliance. Methods for identifying changes may include the following:
- Regular review and updates based on a time schedule established by the hospital
- Monitoring compliance to assess areas of improvement or gaps in performance
- Review of current and relevant research to assess industry changes
- Staff feedback opportunities, including surveys, suggestion boxes, or feedback sessions
- Communication channels to inform staff of policy changes, including e-mail announcements, newsletters, and team meetings
- Employee education and training
- Incident reporting

Measurable Elements of MOI.02.00
1. Ⓓ There is a written guidance document that defines the requirements for reviewing policies and procedures, including the following:
   - Review and approval of all documents by an authorized person before issue
   - Frequency of review and continued approval of documents
   - Controls for ensuring that only current, relevant versions of documents are available
   - Method for identifying changes
2. Ⓓ There is a written guidance document that defines requirements for management of policies and procedures, including the following:
   - Maintaining identity and legibility
   - Managing documents originating outside the hospital
   - Retaining obsolete documents for the time required by laws and regulations while ensuring that they are not used
   - Tracking all documents in circulation (for example, identified by title, date of issue, edition and/or current revision date, number of pages, and who authorized and/or reviewed the document)
3. Ⓓ There are standardized formats for all similar documents (for example, all policies).
4. The requirements of the guidance document are implemented and evident in the policies, procedures, and programs found throughout the hospital.

Standard MOI.02.01

Leaders review, approve, and manage implementation of policies and procedures that guide and support patient care and services.

Intent of MOI.02.01

Throughout the accreditation standards found in this manual, policies, procedures, plans, and other written documents are required (noted with the icon Ⓓ), as they reduce process variation and reduce the risk inherent in processes to improve quality and patient safety.

There is a process to ensure that staff members have read and are familiar with policies, procedures, and plans relevant to their work. This process may be part of the orientation of staff members to their department and responsibilities or may be part of groupwide or hospitalwide special training sessions. When a policy, procedure, or plan is relevant to the assignment of an individual, the intended actions described in the document are evident in the actions of the individual.

Measurable Elements of MOI.02.01

1. Required policies, procedures, and plans are available, and staff understand how to access those documents relevant to their responsibilities.
2. Staff are trained and understand those documents relevant to their responsibilities.
3. The requirements of the policies, procedures, and plans are fully implemented and evident in the actions of individual staff members.
4. The implementation of policies, procedures, and plans is monitored, and the information supports full implementation.

Standard MOI.02.02

The hospital uses standardized diagnosis and procedure codes and ensures the uniform use of approved symbols and abbreviations across the hospital.

Intent of MOI.02.02

Standardization of codes and uniform use of symbols and abbreviations prevents miscommunication and potential errors in patient care and supports data aggregation and analysis.

Abbreviations can be problematic and even dangerous, particularly in the context of prescribing medications. When abbreviations are allowed in the hospital, processes are implemented to prevent or reduce risks to patient safety. Abbreviations are not used on high-risk, patient-specific documents that are crucial to continuity of care, including the following:
- Informed consent documents
- Patient rights documents
- Discharge instructions
- Discharge summaries

Patients and families may not understand the hospital's approved abbreviations. With discharge summaries, there is a patient safety risk in using abbreviations if a provider from a different organization does not use the same list. Abbreviations are typically used on reports of laboratory and diagnostic imaging test results.

The hospital's use of standardized codes and uniform use of approved symbols and abbreviations is consistent with standards of professional practice and complies with local laws and regulations as applicable. Staff are educated and trained on the principles of the standardization and uniform use of the hospital's codes, symbols, and abbreviations.

When a hospital uses abbreviations, the hospital implements a process for the uniform use of approved abbreviations, such as a reference list. This uniform use includes each abbreviation having only one meaning. When abbreviations have more than one meaning, confusion as to what the author meant may result in medical errors. For example, the abbreviation *MS* could mean mitral stenosis in cardiology; however, in neurology, the abbreviation *MS* may be used for multiple sclerosis. In addition, confusion may arise when two abbreviations have the same letters but different letter cases. For example, *Pt* for patient and *PT* for physiotherapy. Even though the use of uppercase and lowercase letters differs between the two examples, they are essentially the same abbreviation with more than one meaning. It is important that abbreviation use is uniform and consistent across the hospital without differences in meanings between different departments or services.

When a hospital uses abbreviations, the hospital develops and/or adopts a do-not-use list of abbreviations and symbols. For example, the Institute for Safe Medication Practices (ISMP) maintains a list of abbreviations, symbols, and dose designations that "should never be used when communicating medical information." The items in the list were reported to ISMP as being frequently misinterpreted and involved in harmful medication errors.