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

IPSG.05.00 The hospital implements evidence-based hand-hygiene guidelines to reduce the risk of health care–associated infections.

Goals, Standards, Intents, and Measurable Elements

Goal 1: Identify Patients Correctly

Standard IPSG.01.00

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

Intent of IPSG.01.00

Incorrect patient identification can result in wrong-person and wrong-procedure errors, treatment errors, medication errors, diagnostic errors, and more that may result in patient harm. Correctly identifying a patient and matching them with intended treatment and services must be performed in all care settings. The identification process used throughout the hospital requires two patient identifiers, such as the patient's name, identification number, birth date, a bar-coded wristband, or other ways. The patient's room number or location in the hospital, or other numbers such as incubator numbers for neonates, cannot be used for identification. The two different patient identifiers used may be different in different circumstances; however, the two identifiers used must be consistent within an area. It is a best practice that the patient be involved in the identification process to whatever extent possible. There are special circumstances in which the hospital may need to develop a specific process for patient identification. The process considers the unique needs of the patients, and staff use the process for patient identification in these special circumstances to prevent error. Two different patient identifiers are required in any circumstance involving patient interventions. Patients are identified before providing treatments, before performing procedures, and before any diagnostic procedures are performed. The hospital should include the following in its patient identification practices:

- Involve the patient in the identification process whenever possible.
- Include special circumstances in the identification process. Examples include the following:
  - Comatose or confused/disoriented patients with no identification
  - Newborn patients when the parents have not immediately chosen a name, such as using the mother's given name in addition to "baby boy" or "baby girl" and the parents' surname (for example, "Baby Girl Mariam Khan" instead of "Baby Girl Khan," or "Baby Boy Maria Silva" instead of "Baby Boy Silva" in the event more than one baby of the same gender has the same last name, and adding a third name such as the father's given name or the mother's middle name if there is the likelihood of two or more patients on the ward with the same given and surname, or multiple births
- Organizations that allow different identifiers to be used in different care areas or scenarios must ensure that the process is consistent in these circumstances, as in the following examples:
  - A patient's name and date of birth are used in verbal interactions with the patient on the ward; these same two identifiers must be used in all verbal interactions with the patient.
  - A patient's name and identification number or medical record number are used during the time-out for surgical/invasive procedures, to label specimens, or to report diagnostic tests, and the like; these same two identifiers must be used in all similar circumstances.
- Patients are identified before providing treatments, before performing procedures, before any diagnostic procedures, and before any other treatments, cares, or interventions intended for a specific patient; this includes labeling any treatments and medications intended for a specific patient. Examples include the following:
  - Blood samples and pathology samples

- Dietary trays
- Expressed mother's milk

Measurable Elements of IPSG.01.00

1. Ⓓ The hospital uses at least two patient identifiers, that do not include the use of the patient's room number or location in the hospital, to identify the patient and to label elements associated with the patient's care and treatment plan. (*See also* MMU.04.01, ME 4; MMU.05.03, ME 4; MOI.03.00, ME 1)
2. The hospital identifies patients with at least two identifiers before performing diagnostic procedures, providing treatments, and performing other procedures. (*See also* MMU.04.01, ME 4)
3. Ⓓ The hospital ensures the correct identification of patients in special circumstances, such as the comatose patient or newborn who is not immediately named.

Goal 2: Improve Effective Communication

Standard IPSG.02.00

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

Intent of IPSG.02.00

Patient harm can result when critical results of diagnostic tests are not reported and acted on promptly. A *critical result* is defined as a variance from normal range that represents a pathophysiologic state that is high risk or life-threatening, is considered urgent or emergent, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic event. This is different from an *abnormal result*, defined as one outside the expected test range but not an urgent or emergent life threat. It is also important to distinguish between *critical* ***tests*** (the diagnostic tests themselves, some of which hospitals may define as being critical by nature) and *critical* ***test results*** (meaning the outcome of any diagnostic test that indicates a very serious or life-threatening condition). This standard and its measurable elements are concerned with *critical* ***test results*** (*outcomes*) from any diagnostic test, and these critical result parameters and the response to them must be established by the hospital. For example, the hospital may define a critical result for potassium levels as being below 2.5 mmol/L or above 6.0 mmol/L, indicating potentially life-threatening hypokalemia or hyperkalemia.

Hospital health care practitioners may consider a result to be very serious in some clinical situations in which the result is not in the defined critical range, such as a mildly low potassium level in the setting of digitalis toxicity. However, those clinical decisions are separate from the purposes of compliance with this standard, which requires the hospital to formally define the parameters of absolute critical ranges for tests, as in the example of critical potassium levels above, and establish a procedure for reporting and response.

Diagnostic tests include all tests, such as laboratory, imaging, and cardiac diagnostics. Critical results may also be produced from any diagnostic tests performed at the bedside, such as point-of-care blood testing, portable imaging, and 12-lead electrocardiograms. Diagnostic tests that produce defined test results that may indicate a threat to life are different from continuous electronic monitoring, such as cardiac telemetry, continuous EEG (electroencephalogram) monitoring, or fetal monitoring. Continuous electronic monitoring is a clinical assessment tool used to detect changes in the patient's condition over time that may identify a threat to life but is not designed to produce a defined critical result.

A formal reporting system is used throughout the hospital that clearly identifies how critical results of diagnostic tests are communicated to health care practitioners and how the information is documented and acted on. This should include closed-loop communication by a read-back between the reporter and the receiver. The objective is to provide the critical results within an established time frame so that the responsible licensed health care provider can evaluate its significance and act on the results within a defined time frame.