QM.16.8 Relevant information developed from patient safety activities is integrated into quality improvement and risk management activities.

QM.16.9 Patient safety activities and their results are communicated to the staff and other relevant groups and used as the base for improving the hospital's processes.

Standard Intent:

The Hospital must have a Patient Safety Program that focuses on the continuous enhancement of safety for all patients, visitors and employees and to reduce the risk to patients and decrease medical errors. The program collects and analyzes aggregate data to support patient care and hospital management. The aggregated data can help the hospital understand its current performance and identify opportunities for improvement as well as to compare with hospital historical data and bench mark with an exemplary performing hospitals or the best practice.

Leadership commitment to patient safety is essential. There should be ongoing patient safety education for physicians, employees and patients. The education programs should create a culture of safety in which employees are encouraged to come forward when they or others make mistakes, allowing the opportunity to improve the care we deliver and prevent potential errors.

QM.17 The hospital has a process to ensure correct identification of patients.

QM.17.1 At least two patient identifiers (e.g., patient full name and medical record number) are required whenever taking blood samples, administering medications or blood products, or performing procedures.

QM.17.2 The hospital has a standardized approach to patient identification (e.g., use of ID bands with standardized information).

QM.17.3 Patients are actively involved in the process of patient identification.

Standard Intent:

To assure correct patient identification and eliminate errors that can have fatal consequences, there should be a standard process for patient identification throughout the healthcare institution.

The identification process should include at least two identifiers (e.g., patient full name and medical record number). The identification process is required in any circumstance involving patient interventions e.g., performing procedures (such as inserting a catheter or performing lumbar puncture), before providing treatment (such as administering medication, or blood and blood products) and before any diagnostic procedures (such as taking blood samples or radiological investigations).

When possible, patients are required to be involved in the identification process.

QM.18 The hospital has a process to prevent wrong patient, wrong site, and wrong surgery/procedure.

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.