- 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.

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