CheckPoint Error Prevention Measurement Methodology

Error Prevention Measurement Methodology

Version 13.2
July 1 to December 31, 2012

Questions or comments can be directed to Geoff McAlister
at 608-274-1820 or gmcalister@wha.org
CheckPoint Error Prevention Measurement Methodology

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The following are also available as separate documents on CheckPoint’s Resource Documents
page:
APPENDIX D – ICD-9 CODES FOR SURGICAL GOALS
APPENDIX E – CPT CODES FOR SURGICAL GOALS
APPENDIX F – HISTORIC CHANGES TO ERROR PREVENTION MEASUREMENT METHODOLOGY

The link for the Resource Documents page is:
CheckPoint Error Prevention Measurement Methodology

CHANGES TO ERROR PREVENTION METHODOLOGY

7/1/2012 through 12/31/2011
• Remove Measure #6, Medication Reconciliation at Admission.
• Add Measure #7, Medication Reconciliation Upon Discharge.

7/1/2011 through 12/31/2011
• Remove Additional Data Collection: Patient Initiation of the Medication Reconciliation Process.
• Rewrite Medical Reconciliation Measure Spec:
  o Adjust language to simplify process for hospitals with EHRs.
  o Remove any specific time requirement for initiation of Med Rec process, instead deferring to hospital policy.

1/1/2011 through 6/30/2011
• Remove Measure #3, Standardize Abbreviations

There were no other changes to this methodology in the past two years.
CheckPoint Error Prevention Measurement Methodology

The error prevention measures included in the CheckPoint quality public reporting program reflect a sub-set of The Joint Commission (TJC) National Patient Safety Goals. This document includes a brief overview of each goal, as well as the measure specifications that the Wisconsin Hospital Association (WHA) will be using to measure progress towards TJC goals selected for public reporting. WHA makes no claim to be the authority on TJC national patient safety goals. To obtain additional information regarding the purpose and specific requirements of TJC national patient safety goals, please refer to TJC website, www.jointcommission.org or contact your TJC representative.

SCORING

The score for each measure will consist of one component, the demonstrated success rate (DSR) worth a maximum of 100 percent.

<table>
<thead>
<tr>
<th>Components</th>
<th>Response Options</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Demonstrated Success Rate (DSR)</strong>: varies by measure</td>
<td>Collected Rate</td>
<td>0-100</td>
</tr>
</tbody>
</table>
DATA COLLECTION AND REPORTING

The following pages contain general information about each error prevention measure, as well as detailed instructions on how to collect the Demonstrated Success Rate. In addition, data collection worksheets are provided in Appendix A and C to assist in recording your information.

Your hospital’s data will be collected through the CheckPoint Hospital Administration site provided by WHA. If you do not have security access to this site, please contact Geoff McAlister at 608-268-1817 or gmcalister@wha.org. The error prevention measures data entry portion of the CheckPoint Hospital Administration site has a format similar to the data collection worksheet included in this document. Therefore, if you use the data collection worksheet to record your information as you gather it, entering the data into the CheckPoint Hospital Administration site should require minimal additional time.

**Reporting Period**

Cases should be identified from discharges that occurred between **7/1/2012 and 12/31/2012**.

**Data Due Date**

All data should be collected and entered into the CheckPoint Hospital Administration site by **2/28/2013**.

AUDITING AND RECORD RETENTION REQUIREMENTS

Participating hospitals are randomly selected every 6 months for the CheckPoint error prevention audit. If your hospital is selected, you will be contacted by WHA.

The purpose of the audit is to assess your hospital’s compliance to the CheckPoint Error Prevention Measurement Methodology and will focus on the verification of the demonstrated success rates for each measure. **For audit purposes, it is important you retain a list (audit trail) of the cases or medication orders used for the calculation of each measure’s demonstrated success rates for 1 year after the reporting period end date.**

**Questions and Comments**

Questions or comments regarding this publication may be directed to Geoff McAlister, Senior Director of Information Systems, WHA, at 608-268-1817 or gmcalister@wha.org.

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MEASURE #1 – SURGICAL SITE MARKING
Implement a process to mark the surgical or invasive procedure site and involve the patient in the marking process when possible.

General Information
- The site does not need to be marked for bilateral structures. Examples: tonsils, ovaries
- For spinal procedures: Mark the general spinal region on the skin. Special intraoperative imaging techniques may be used to locate and mark the exact vertebral level.
- Mark the site before the procedure is performed.
- If possible, involve the patient in the site marking process.
- The site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed.*
- Ultimately, the licensed independent practitioner is accountable for the procedure – even when delegating site marking.
  * In limited circumstances, site marking may be delegated to some medical residents, physician assistants (P.A.), or advanced practice registered nurses (A.P.R.N.).
- The mark is unambiguous and is used consistently throughout the organization.
- The mark is made at or near the procedure site.
- The mark is sufficiently permanent to be visible after skin preparation and draping.
- Adhesive markers are not the sole means of marking the site.
- For patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (see examples below): Use your organization’s written, alternative process to ensure that the correct site is operated on. Examples of situations that involve alternative processes:
  o mucosal surfaces or perineum
  o minimal access procedures treating a lateraled internal organ, whether percutaneous or through a natural orifice
  o interventional procedure cases for which the catheter or instrument insertion site is not predetermined
    - Examples: cardiac catheterization, pacemaker insertion
  o teeth
  o premature infants, for whom the mark may cause a permanent tattoo

Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

Please refer to TJC Universal Protocol (Appendix B) for complete details on how to implement this goal.
Demonstrated Success Rate (DSR) Collection Process

The demonstrated success rate for this measure can be obtained through retrospective case review or concurrent observation.

Note: You may use the same cases to collect the data for measures #1 and 2 to reduce the burden of data collection. It should be noted that TJC requirement related to measure #2 includes more cases than those being used for this data collection.

| Numerator | Number of surgical and invasive procedures where the surgical site was marked prior to incision and the patient was involved in the marking | X 100 |
| Denominator | Total number of surgical and invasive procedures reviewed/observed |

Specifications

- This measure applies to all surgical and invasive procedures that meet TJC requirement for site marking as defined by the Universal Protocol. For the purpose of this data collection, you should include surgical and invasive procedures from the following patient care areas as they apply to your organization.
  - Inpatient surgery
  - Ambulatory/same day surgery
  - Observation patients
  - Outpatient surgery and procedures performed in the hospital setting

You should not include surgical and invasive procedures performed in a clinic setting or other units that are not managed within your hospital’s organizational structure.

- The minimum number of cases that should be included in this sample is 75.
  - If a case includes more than one procedure that meets the requirement for site marking, each procedure may be counted separately towards the 75 case minimum.
  - Hospitals that have more than 75 cases, whether you are sampling or not, must submit at least 75 cases. You may choose to use a larger sample size than is required. If you do so, you must report on all cases in your sample.
  - Hospitals that do not have 75 cases in 6 months, may submit data as long as you have at least 30 cases. In this situation, you should submit all cases that meet the criteria.
  - Hospitals that do not have at least 30 cases in the six-month data collection period, should not report results to CheckPoint for that six-month period.

- Cases used for this measure include procedures with ICD-9-CM Procedure codes listed in Appendix D or CPT codes listed in Appendix E.

- The case has the ICD-9 or CPT code listed as either a principal or secondary procedure.
Data Collection

Retrospective Review

Retrospective case review includes data that is documented in the patient record, internal use form(s), or databases, and reviewed at a later date. The distinguishing characteristic of retrospective case review is that the information is documented at the time of the site marking and reviewed at a later date.

If you have between 30 and 74 cases, use all of them in your sample.

If you have between 75 and 149 cases: Take the total number of cases and subtract 75. This will give you the number of cases that can be removed from your population. Divide the total number of cases in your population by the number of cases that can be removed from your population. Round down to the nearest whole number to identify the \( n \)th patient. Remove every \( n \)th patient from your population.

Example: Total number of cases = 90 cases

Step 1: 90 cases – 75 case minimum = 15 additional cases
Step 2: 90 cases / 15 additional cases = 6 (round down if needed)
Step 3: Remove every 6\( \text{th} \) case from your population to create your sample

If you have 150 cases or more: Take the total number of cases in your population and divide by 75. Round down to the nearest whole number to identify the \( n \)th patient. Select every \( n \)th patient for inclusion in your population.

Example: Total number of cases = 359

Step 1: 359 cases / 75 case minimum = 4.79 (Round down to 4)
Step 2: Select every 4\( \text{th} \) case from your population to create your sample

Concurrent Observation or Collection

If your hospital does not have a process to document site marking in the patient record or chooses to do concurrent data collection, you will need a process to determine if the surgical site was marked with the patient’s input prior to the start of the procedure. To do this, you should identify a consistent time in the surgical process and a consistent staff role to conduct the review and document the results.

You will need to estimate the number of cases you expect to have in six months based on previous average caseload per month. Refer to procedures with ICD-9-CM procedure codes listed in Appendix D or the CPT codes listed in Appendix E.
MEASURE #2 – TIMEOUT/VERIFICATION PROCESS
Prior to the start of any surgical or invasive procedure, conduct a final verification process to confirm the correct patient, procedure(s) and site(s). The procedure is not started until all questions or concerns are resolved.

General Information
• Conduct a time-out immediately before starting the invasive procedure or making the incision.
• A designated member of the team starts the time-out.
• The time-out is standardized.
• The time-out involves the immediate members of the procedure team: the individual performing the procedure, anesthesia providers, circulating nurse, operating room technician, and other active participants who will be participating in the procedure from the beginning.
• All relevant members of the procedure team actively communicate during the time-out.
• During the time-out, the team members agree, at a minimum, on the following:
  ▪ correct patient identity
  ▪ correct site
  ▪ procedure to be done
• When the same patient has two or more procedures: If the person performing the procedure changes, another time-out needs to be performed before starting each procedure.
• Document the completion of the time-out. The organization determines the amount and type of documentation.

Please refer to TJC Universal Protocol (Appendix B) for complete details on how to implement this goal.

Demonstrated Success Rate (DSR) Collection Process
The demonstrated success rate for this measure can be obtained through retrospective case review or concurrent observation.

Note: You may use the same cases to collect the data for measures #1 and 2 to reduce the burden of data collection. It should be noted that TJC requirement related to measure #2 includes more cases than those being used for this data collection.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of procedures where a verification process occurred to confirm the correct patient, procedure(s), site(s), position and availability of equipment</th>
<th>X 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of surgical and invasive procedure reviewed/observed</td>
<td></td>
</tr>
</tbody>
</table>

Specifications
CheckPoint Error Prevention Measurement Methodology

- This measure applies to all surgical and invasive procedures that meet TJC requirement for a verification process as defined by the Universal Protocol. For the purpose of this data collection, you should include surgical and invasive procedures from the following patient care areas as they apply to your organization.
  - Inpatient surgery
  - Ambulatory/same day surgery
  - Observation patients
  - Outpatient surgery and procedures performed in the hospital setting

You should not include surgical and invasive procedures performed in a clinic setting or other units that are not managed within your hospital’s organizational structure.

- The minimum number of cases that should be included in this sample is 75.
  - Hospitals that have more than 75 cases, whether you are sampling or not, must submit at least 75 cases. You may choose to use a larger sample size than is required. If you do so, you must report on all cases in your sample.
  - Hospitals that do not have 75 cases in 6 months, may submit data as long as you have at least 30 cases. In this situation, you should submit all cases that meet the criteria.
  - Hospitals that do not have at least 30 cases in the six-month data collection period, should not report results to CheckPoint for that six-month period.

- Cases used for this measure include procedures with ICD-9-CM procedure codes listed in Appendix D or CPT codes listed in Appendix E.

- The case has the ICD-9 or CPT code listed as either a principal or secondary procedure.

Data Collection

Retrospective Review

Retrospective case review includes data that is documented in the patient record, internal use form(s), or databases, and reviewed at a later date. The distinguishing characteristic of retrospective case review is that the information is documented at the time the verification process occurs and is reviewed at a later date.

If you have between 30 and 74 cases, use all of them in your sample.

If you have between 75 and 149 cases: Take the total number of cases and subtract 75. This will give you the number of cases that can be removed from your population. Divide the total number of cases in your population by the number of cases that can be removed from your population. Round down to the nearest whole number to identify the $n$th patient. Remove every $n$th patient from your population.

Example: Total number of cases = 90 cases

Step 1: 90 cases − 75 case minimum =15 additional cases
Step 2: 90 cases / 15 additional cases = 6 (round down if needed)
Step 3: Remove every 6th case from your population to create your sample
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If you have 150 cases or more: Take the total number of cases in your population and divide by 75. Round down to the nearest whole number to identify the $nth$ patient. Select every $nth$ patient for inclusion in your population.

Example: Total number of cases = 359

Step 1: 359 cases / 75 case minimum = 4.79 (Round down to 4)
Step 2: Select every 4th case from your population to create your sample

Concurrent Observation or Collection

If your hospital does not have a process to document the verification process or prefer to do concurrent data collection, you will need a process to determine if a complete verification process occurred. To do this, you should identify a consistent time in the surgical process and a consistent staff role to conduct the review and document the results.

You will need to estimate the number of cases you expect to have in six months based on previous average caseload per month. Refer to procedures with ICD-9-CM procedures listed in Appendix D or CPT codes listed in Appendix E, both available as separate documents.
MEASURE #7 – MEDICATION RECONCILIATION UPON DISCHARGE

Measure Timing
Data collection to begin 7/1/2012

General Information
Medication reconciliation on discharge is a formal process for preparing an accurate list of medications each patient should be taking after they leave the hospital. This measure is limited to inpatients. This process involves the following steps:

- Comparing and reviewing the list of medications the patient was taking upon admission, with the medications the patients was receiving on the day of discharge, with the physicians’ discharge orders or other physician documentation such as a Medication Reconciliation Worksheet, resulting in
  - Decision to restart, continue, discontinue or modify each medication the patient was taking on admission to the hospital.
  - Decision to continue, discontinue or modify each medication the patient was receiving, as an inpatient, on the day of discharge. This includes all medications the patient was taking during the hospital stay that will be continued after discharge.
  - Details regarding any medications the patient will first start taking after discharge.

Demonstrated Success Rate (DSR) Collection Process
The demonstrated success rate for this measure is derived through case review.

Numerator: Number of patients with a completed medication reconciliation before the patient leaves the facility (Column E of Appendix C)

Denominator: Total number of cases reviewed

Specifications:
1. This measure is limited to inpatient discharges
2. A qualified individual designated by the hospital must perform the medication comparison and review. The discharge medication list must be prepared with input from a qualified individual of the medical staff.
3. Preparation of an accurate medication list, on discharge
   a. The medication list and documentation of the reconciliation may be electronic or a paper form.
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b. The medication list is considered “complete” when all data elements required by hospital policy are documented.

c. Typical data elements, for each medication may include:
   i. Name of medication
   ii. Dose
   iii. Frequency
   iv. Route
   v. Purpose for taking the medication
   vi. Special instructions for the patient

d. There must be evidence that the list was reviewed and/or updated, on discharge.

e. Record on WHA Discharge Medication Reconciliation Data Collection Form, column C

4. Reconciliation and resolution of discrepancies

   a. Reconciliation must include a clearly documented decision to continue, discontinue, or modify all medications the patient was taking on admission.
      i. This includes but is not limited to prescription, over-the-counter, and homeopathic medications, as well as vitamins, herbals, nutritional supplements, and medications taken on an “as needed” (PRN) basis.
      ii. If your organization has a policy that excludes over-the-counter medications, homeopathic medications, vitamins, herbals or nutritional supplements from the medication reconciliation process, you may consider these medications reconciled for the purpose of this data collection.

   b. Reconciliation must include a clearly documented decision to continue, discontinue, or modify all medications the patient was taking on the day of discharge.

   c. Reconciliation must include a documented decision regarding all “as needed” (PRN) medications that were ordered for the patient during the hospital stay.

   d. Reconciliation must include clearly documented information for all medications the patient will first start taking after discharge.

   e. If the patient was on no medications prior to admission and will be taking no medications after discharge the record should be considered reconciled for this data collection.

   f. Discrepancies include omissions, duplications, contraindications, unclear information and changes made during hospitalization. All discrepancies must be resolved and documented prior to final printing of the discharge medication list.

Data Collection

- The minimum number of cases that should be included in this sample is 75.
  o Hospitals that have more than 75 cases, whether you are sampling or not, must submit at least 75 cases. You may choose to use a larger sample size than is required. If you do so, you must report on all cases that you include in your sample.
  o Hospitals that do not have 75 cases in 6 months, may submit data as long as you have at least 30 cases. In this situation, you should submit all cases that meet the criteria.
  o Hospitals that do not have at least 30 cases in the six-month data collection period, should not report results to CheckPoint for that six-month period.
  o Data can be collected electronically, manually or a combination of both.
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- **Data Elements:**
  - Evidence exists that all medications the patient was taking on admission were reconciled with the discharge medication list (*Column C on Appendix C*).
  - Evidence exists that all medications that were on the active medication list on the day of discharge were reconciled with the discharge medication list (*Column D of Appendix C*).
  - Medication reconciliation on discharge is considered "Complete" when both of the above steps are completed.

- **Inclusion criteria** - All *inpatients* that receive medications during this hospitalization should be included in this data collection.

- **Exclusion criteria**
  - Patients that expired

**Sample Size for Retrospective Review**

*If you have between 30 and 74 cases, use all of them in your sample.*

*If you have between 75 and 149 cases:* Take the total number of cases and subtract 75. This will give you the number of cases that can be removed from your population. Divide the total number of cases in your population by the number of cases that can be removed from your population. Round down to the nearest whole number to identify the *nth* patient. Remove every *nth* patient from your population.

**Example:** Total number of cases = 90 cases

Step 1: 90 cases – 75 case minimum =15 additional cases
Step 2: 90 cases / 15 additional cases = 6 (round down if needed)
Step 3: Remove every 6th case from your population to create your sample

*If you have 150 cases or more:* Take the total number of cases in your population and divide by 75. Round down to the nearest whole number to identify the *nth* patient. Select every *nth* patient for inclusion in your population.

**Example:** Total number of cases = 359

Step 1: 359 cases / 75 case minimum = 4.79 (Round down to 4)
Step 2: Select every 4th case from your population to create your sample

**Sample Size for Concurrent Observation or Collection**

If your hospital chooses to do concurrent data collection, you will need a process to determine if the medication reconciliation process was completed prior to discharge. You will also need to estimate the number of cases you expect to have in six months based on previous average caseload per month.
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ERROR PREVENTION MEASURE #7: MEDICATION RECONCILIATION UPON DISCHARGE

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrated Success Rate (DSR)</td>
<td>Numerator</td>
</tr>
<tr>
<td><em>See Appendix C for data collection form</em></td>
<td>Denominator</td>
</tr>
<tr>
<td>Rate ((\text{Num.}/\text{Den.} \times 100))</td>
<td>Rate</td>
</tr>
</tbody>
</table>

Created and Approved by WHA Measures Team: 3/9/2012
### Appendix A – Site Marking Data Collection Worksheet

**ERROR PREVENTION MEASURE #1: IMPLEMENT A PROCESS TO MARK THE SURGICAL SITE AND INVOLVE THE PATIENT IN THE MARKING PROCESS**

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrated Success Rate (DSR)</td>
<td>Numerator ________</td>
</tr>
<tr>
<td></td>
<td>Denominator ________</td>
</tr>
<tr>
<td></td>
<td>Rate (Num./Den. X 100) ________</td>
</tr>
</tbody>
</table>

This DSR was collected using: Retrospective case review _____ Concurrent observation _____

**ERROR PREVENTION MEASURE #2: PRIOR TO THE START OF ANY SURGICAL OR INVASIVE PROCEDURE, CONDUCT A FINAL VERIFICATION PROCESS TO CONFIRM THE CORRECT PATIENT, PROCEDURE(S) AND SITE(S) USING ACTIVE COMMUNICATION TECHNIQUES**

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrated Success Rate (DSR)</td>
<td>Numerator ________</td>
</tr>
<tr>
<td></td>
<td>Denominator ________</td>
</tr>
<tr>
<td></td>
<td>Rate (Num./Den. X 100) ________</td>
</tr>
</tbody>
</table>

The DSR was collected using: Retrospective case review _____ Concurrent observation _____

**ERROR PREVENTION MEASURE #6: MEDICATION RECONCILIATION UPON ADMISSION**

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrated Success Rate (DSR)</td>
<td>Numerator ________</td>
</tr>
<tr>
<td></td>
<td>Denominator ________</td>
</tr>
<tr>
<td></td>
<td>Rate (Num./Den. X 100) ________</td>
</tr>
</tbody>
</table>

*See Appendix C for data collection form*
Appendix B – Universal Protocol

Sources: http://www.jointcommission.org/standards_information/up.aspx

UP.01.01.01
Conduct a pre-procedure verification process.
Note: CheckPoint does not track this pre-procedure verification process.

Rationale for UP.01.01.01
Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:
- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient’s identifiers
- Reviewed and are consistent with the patient’s expectations and with the team’s understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:
- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

Elements of Performance for UP.01.01.01
1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. Note: The patient is involved in the verification process when possible.
2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
   - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
   - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
   - Any required blood products, implants, devices, and/or special equipment for the procedure
   Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.
3. Match the items that are to be available in the procedure area to the patient.
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UP.01.02.01
Mark the procedure site.

Rationale for UP.01.02.01
Marking the procedure site allows staff to identify without ambiguity the intended site for the procedure.

Elements of Performance for UP.01.02.01
At a minimum, mark the site when there is more than one possible location for the procedure and when performing the procedure in a different location could harm the patient.

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.

   Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.

3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
   - An individual in a medical residency program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed
   - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse (A.P.R.N.) or physician assistant (P.A.)); who is familiar with the patient; and who will be present when the procedure is performed.

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.

   Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).

   Note: Examples of other situations that involve alternative processes include:
   - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
   - Interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion)
   - Teeth
   - Premature infants, for whom the mark may cause a permanent tattoo
UP.01.03.01

A time-out is performed before the procedure.

**Rationale for UP.01.03.01**

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a timeout, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

**Elements of Performance for UP.01.03.01**

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.

2. The time-out has the following characteristics:
   - It is standardized, as defined by the hospital.
   - It is initiated by a designated member of the team.
   - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.

4. During the time-out, the team members agree, at a minimum, on the following:
   - Correct patient identity
   - The correct site
   - The procedure to be done

5. Document the completion of the time-out.
   Note: The hospital determines the amount and type of documentation.
## Appendix – C Medication Reconciliation Data Collection Form

### Appendix C

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**Notes on Discrepancies**

**Reviewer's Initials**

**Is discharge med reconciliation complete?**

(Column C & D must be “yes”) (Y/N)
# Appendix – C Medication Reconciliation Data Collection Form

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