HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Quality Management and Patient Safety		
Document:	Departmental Policy and Procedure		
Title:	The Quality Management Plan		
Applies To:	All Quality Department		
Preparation Date:	November 10, 2024	**Index No:**	QM&PS-DPP-005
Approval Date:	November 24, 2024	**Version :**	2
Effective Date:	December 24, 2024	**Replacement No.:**	QM&PS-DPP-005 (1)
Review Date:	December 24, 2027	**No. of Pages:**	15

1. INTRODUCTION:

1.1 In pursuit of quality and reaching excellence in the services we provide every day to our customers; we need to change and adopt the philosophy of managing and improving our processes continuously while ensuring safety at all levels of service provision.

1.2 Maternity & children hospital (MCH) — Hafar Al Batin, under the umbrella of the Ministry of Health (MOH) shall strive to provide quality and safe services in a Quality Management (QM&PS) system. This will require thorough understanding of the concepts of QM&PS, Patient Safety and the implementation of the continuous improvement methodology in the organization.

1.3 This plan shall outline the QM&PS program of MCH — Hafar Al Batin, identifying the roles and responsibilities of hospital administration, departments, staff and teams in the implementation of the quality management (QM) initiatives, the education plan for quality improvement (QI) and the integration of systems towards continuous improvement of services. This plan also integrates the Patient safety goals of the hospital in line with the International Safety Goals identified by the Joint Commission International in 2016.

1.4 The MCH QM plan will serve as a guide for departments and functions in establishing their respective quality improvement plans and patient safety objectives to be achieved in accordance with their scope of services.

2. MCH MISSION STATEMENT

2.1 To provide compassionate family centered exceptional healthcare to the women and children in our community.

3. MCH VISION STATEMENT:

3.1 To be the healthcare leader for women and children in the region.

4. MCH VALUES:HEALTHCARE

4.1 Motivation:
4.2 Always looking for excellency
4.3 Empowerment:
4.4 Building capacities before performance.
4.5 Collaboration:
4.6 Team-work spirit in provision of services.
4.7 Commitment
4.8 The support, participation and the roll-model in the performance.
4.9 Accountability
4.10 Self-monitoring to bear the responsibility towards organization excellency.

3. DEFINITION:

3.1 MCH shall define Quality Management and Patient Safety (QM&PS) as follows:

3.1.1 **Quality:** is meeting and exceeding customers' needs and expectations

3.1.2 **Management:** is achieving total quality needs planning, implementation, monitoring and continuous improvement.

3.1.3 **Patient Safety:** Freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events.

4. THE 10 PILLARS OF CONTINUOUS SERVICE IMPROVEMENT:

4.1 Management vision and commitment
4.2 Accountability
4.3 Measurement and feedback
4.4 Problem solving and process improvement
4.5 Communication
4.6 Staff development and training
4.7 Physician involvement
4.8 Reward and recognition
4.9 Employee improvement and empowerment
4.10 Reminders and refreshers

3 PLAN GOALS AND OBJECTIVES

3.1 **The goals of the Quality Management (QM) and Patient Safety Plan are**:

3.1.1 To ensure continuous improvement of the quality of services rendered to the MCH internal and external customers

3.1.2 To improve patient safety and reduce risk to patients

3.1.3 The objectives in reaching the goals are:

3.1.4 Ensure awareness and comprehension of the hospital's mission, vision and value statements by all hospital employees

3.1.5 Align the QM and patient safety plan with the hospital's mission

3.1.6 Educate the hospital leaders and employees in QM principles, patient safety goals and QI methodology and tools.

3.1.7 Create a hospital-wide environment of shared responsibility for quality and patient safety, with the involvement of all professionals.

3.1.8 Encourage pursuit of opportunities to improve services

3.1.9 Increase decision-making that is data driven

3.1.10 Identify and utilize process-specific and performance-specific measures/indicators

3.1.11 Establish mechanism to ensure QM&PS education and accreditation programs achievements are sustained.

3.1.12 Ensure an environment that is safe for all patients, visitors and staff

3.1.13 Contribute to cost containment efforts by assisting in achieving efficiency through effective utilization of available resources and reducing liability potential

3.1.14 Evaluate and modify the QM and Patient Safety program and the QM&PS department plans annually

3.2 **MCH Prioritization Criteria**: In carrying out quality improvement initiatives in the hospital, departments and teams should prioritize improvement activities that meet one or more of the following criteria

3.2.1 High volume diagnoses/procedures/ and other operational and business processes

3.2.2 High risk diagnoses/procedures and other operational and business processes

3.2.3 Problem prone diagnoses/procedures and other operational and business processes

3.2.4 High cost diagnoses/procedures and other operational and business processes

3.2.5 High complex processes and services

3.3 **MCH Patient Safety Goals:** In line with the Joint Commission International defined Patient Safety goals, MCH has selected the following goals to be achieved through education and monitoring.

3.3.1 Identify patients correctly.
3.3.2 Improve effective communication.
3.3.3 Improve the safety of high alert medication
3.3.4 Eliminate wrong-site, wrong-patient, wrong procedure.
3.3.5 Reduce the risk of health care-acquired infections.
3.3.6 Reduce the risk of patients harm resulting from falls.

The protocols and monitoring details of each goals is explained the Appendixes.

3.4 **MCH Quality Improvement Methodology**

3.4.1 The MCH method to carry out improvement activities are guided by Ada' a Improvement methodology which is installed by MOH & the FOCUS — PDCA methodology defined as follows:

3.4.1.1 **F: Find** an opportunity for improvement
3.4.1.2 **O: Organize** a team
3.4.1.3 **C: Clarify** the process
3.4.1.4 **U: Understand** the sources of the problem and the process variation S: Select the desired outcome/ the change/ the improvement
3.4.1.5 **S: Select** the process improvement.
3.4.1.6 **P: Plan** the improvement
3.4.1.7 **D: Do** the improvement
3.4.1.8 **C: Check** the results (is the change an improvement?)
3.4.1.9 **A: Act** to hold the gain or make necessary changes

3.5 **Communication and reporting:**

3.5.1 The QM&PS program will be implemented through communications of reports and meetings as follows:

3.5.2

Report	Frequency of Reporting	Participating/Issuing Department	Receiving Entity
2 months Quality Management Committee (QMC) meeting minutes	Monthly	QMC	Directorate of Health Affairs in Hafar AlBatin
Departmental Qi reports	Bi-annually	QM&PS - Departmental QI teams	Quality Management Committee
Committee Annual reports	Annually	Respective committees	Quality Management Committee Executive Committee Medical Executive Committee
Departmental annual reports	Annually	Respective departments	Reporting authority (per organization chart)
Departmental meetings (weekly and monthly)	Monthly Weekly	Respective departments	Reporting authority (per organization chart)
Mortality Reports	Monthly	Medical Records Dept.	Mortality and Morbidity Committee
Committee and Task Force meetings (frequency & functions per team charter	Bi-annually	QM&PS	Quality Management Committee Executive Committee Medical Executive Committee
Occurrence summary reports	Quarterly	QM&PS	Quality Management Committee Patient Safety committee

			Pharmacy & Therapeutics Committee Infection Control Committee Specific Departments Concerned
QM meetings with QM&PS Director, Health Affairs	Monthly	QM&PS	Hospital Administration
Meeting with external organizations summary	Annually	QM&PS	Quality Management Committee
Utilization reviews conducted by Hospital committees	Quarterly	Respective committees	QMC - QM&PS office - Medical Executive Committee

3.6 **Reporting systems of near misses and other patient risk factors:**

3.6.1 Occurrence Variance Reporting system is used to report:

3.6.1 Mistakes and near misses

3.6.1 Injuries or exposure to risks to patient

3.6.1 Injuries or exposure to risks to occupational hazards to staff

3.6.2 Sentinel Event Reporting form

3.6.3 Medication Error Reporting form

3.6.4 Adverse Drug Reaction Reporting form

3.7 **Other Data sources:**

3.7.1 Code Blue outcomes

3.7.2 Patient satisfaction survey

3.7.3 Patient complaints report

3.7.4 Use of blood and blood components reports

3.7.5 Infection control surveillance

3.7.6 Patient identification policy implementation monitoring tool

3.7.7 Random chart reviews for selected goals periodically

3.8 **Patient safety Review Methodologies:**

3.8.1 OVR reports

3.8.2 Mortality and Morbidity Review

3.8.3 Sentinel events summary

3.8.4 Adverse Drug Reaction (ADR) reports

3.8.5 OR review

3.8.6 Blood utilization review

3.8.7 Blood transfusion review

3.8.8 Drug utilization review

3.8.9 Medication error reports

3.8.10 Patient chart review

3.8.11 Allergy reports

3.8.12 Patient Identification errors monitoring per unit

3.8.13 Patient falls monitoring per unit

3.9 **Information Handling:**

3.9.1 The Quality network:

3.9.1.1 The quality network in MCH aims to be of multidisciplinary structure. It coordinates the quality management and improvement initiatives in the organization. It integrates quality and performance improvement activities with the operational processes.

3.9.1.2 The network involves QI projects, which are identified in two types. Large-scale projects are initiated by the Hospital Management to support key strategic and operational objectives. The senior management through the QMC and the Executive Committee monitors these projects.

3.9.1.3 Small-scale projects are more localized. They are performed within departments or interdepartmental. QI teams are formed to carry out these projects. The departments or QI teams initiate these projects and report its progress to related committees, department heads and the QMC.

3.9.1.4 All improvement projects are logged into a database maintained by the Quality and Patient Safety Advocacy department.

3.9.2 QM&PS and Patient Safety planning, implementation and evaluation plan: As MCH is a facility of the MOH and Directorate of Health Affairs in Hafar Al Batin adopts the QM&PS philosophy and systems. MCH shall follow the lead of the MOH in implementing its requirements and communicating QI and patient safety initiatives with the Directorate of Health Affairs in the City of Hafar Al Batin.

3.10 **Hospital-wide commitment and responsibility is defined as follows**:

3.10.1 **MCH Self-Operation Program Director/ QM&PS Program Director**- The Self-Operation Program (SOP) Director will act as the mentor of the QM&PS initiative and will:

- 3.10.1.1 Will be committed to QM program and objectives
- 3.10.1.2 Empower and trust employees
- 3.10.1.3 Assess the QM&PS efforts
- 3.10.1.4 Approve plans in achieving desired outcomes
- 3.10.1.5 Support the identification and reporting of occurrences and near misses.
- 3.10.1.6 Encourage a culture of no blame on those who report incidents and occurrences
- 3.10.1.7 Review reports relevant to Patient Safety issues periodically
- 3.10.1.8 Facilitate the functional fulfilment of accreditation agencies' requirements.

3.10.2 **The Quality and Patient Safety department** -acts as a resource unit that supports all departments and functions in actualizing the hospital mission and values towards reaching its vision and goals of international standards of service quality.

3.10.3 The following are the responsibilities of the Quality and Patient Safety Advocacy department:

- 3.10.3.1 Facilitation of QI projects and teams
- 3.10.3.2 Developing and monitoring of a tracking system for QI projects
- 3.10.3.3 Maintain and monitor multidisciplinary teams program
- 3.10.3.4 Maintain and monitor the policy and procedure program
- 3.10.3.5 Monitoring and maintaining the Occurrence Variance Report (OVR) system
- 3.10.3.6 Monitoring and maintaining the Sentinel Events system
- 3.10.3.7 Consultation and liaison on QI issues:
- 3.10.3.8 Data collection, analysis and use of data for improvement
- 3.10.3.9 Use of outcome measures and the role of clinical indicators
- 3.10.3.10 Facilitation of utilization management activities
- 3.10.3.11 Support and administrative coordination for the QMC
- 3.10.3.12 Support for on-going accreditation and compliance activities
- 3.10.3.13 Support the hospital teams and departments in setting and achieving desired standards

3.11 **Patient Safety Team:**

3.11.1 The purpose of the team is to establish an effective process to implement Patient Safety and follow through of the system.

3.11.1.1 To establish a mechanism on how to implement the Patient Safety Goals.

3.11.1.1.1 To develop, review and revise policies related to the hospital patient safety:

- 3.11.1.1.1.1 Patient identification
- 3.11.1.1.1.2 Time out verification process
- 3.11.1.1.1.3 Standardized hospital abbreviation as well as the non-approved abbreviation
- 3.11.1.1.1.4 Verbal and telephone order
- 3.11.1.1.1.5 Concentrated electrolyte
- 3.11.1.1.1.6 Patient identification

3.11.1.1.1.7 Time out verification process
3.11.1.1.1.8 Standardized hospital abbreviation as well as the non-approved abbreviation
3.11.1.1.1.9 Verbal and telephone order
3.11.1.1.1.10 Concentrated electrolyte
3.11.1.1.1.11 Protocol for administration and documentation of the Flu Vaccine

3.11.1.1.2 To design an assessment to assess the risk in the provision of safe patient care
3.11.1.1.3 To conduct patient safety survey to assess the practice and how effective the patient safety plan
3.11.1.1.4 To review and discuss identified patient safety issues and concerns (adverse events and near misses) and recommends practical actions.
3.11.1.1.5 To promote staff awareness and education of Patient Safety Goals through departmental orientation programs.

3.11.1.2 To monitor adherence to the Patient Safety Measures.
3.11.1.3 To identify roles and responsibilities in implementing Patient Safety Goals.
3.11.1.4 To recommend actions for improvement in meeting the Patient Safety Goals.

3.12 **Departmental Quality Improvement Teams:**

3.12.1 Liaisons with the Quality and Patient Safety Advocacy Department in implementing the QI initiatives at MCH
3.12.2 Develop and implement departmental QI Plans in cooperation with department heads and QM&PS department.
3.12.3 Communicate departmental QI plans and efforts to QMC
3.12.4 Responsible to facilitate the QI initiatives in their respective departments through:
3.12.5 Conducting monthly QI meetings and communication of minutes to QM&PS department
3.12.6 Coordinate the implementation of the JCI & CBAHI requirements within the scope of respective departments
3.12.7 Coordination of departmental quality improvement projects
3.12.8 Keep staff updated on QM&PS information and systems implementations

3.13 **Multi-disciplinary Quality Improvement Project Teams:**

3.13.1 The Teams are charged by the management or QMC and use the FOCUS PDCA methodology & other methodologies to identify and carry out cross-functional improvement activities.
3.13.2 The teams are composed of:
3.13.2.1 Team-leader: usually the initiator of the project or the one who has most ownership of the area addressed
3.13.2.2 Facilitator: neutral person with expertise in QI tools and problem solving skills as well as people and team management skills.
3.13.2.3 Team members: representatives of departments and/or functions affected by the changes resulted from the improvement project and or experts in the subject addressed.
3.13.3 The teams are required to fill out applications to carry out the QI project and report progress to the QMC.

3.14 **Key functions and departments:** Department and committee leaders are supporters to the implementation of the QM plan by carrying out the following:

3.14.1 Identify and review ongoing performance measures
3.14.2 Ensure implementation of the QI methodology adopted by QPS dept.
3.14.3 Recommend improvement projects and teams
3.14.4 Ensure that decisions are data-based and scientific
3.14.5 Monitor safety and effectiveness of care/services based on established standards
3.14.6 Establishing effective communication channels
3.14.7 Coordinate and support Patient Rights Committee
3.14.8 Ensuring secure work environment for staff to improve reporting

3.14.9 Participate and coordinate with concerned departments in addressing patient safety occurrences and analysis

3.15 **Medical and hospital staff members:**

3.15.1 Holding a proactive attitude towards occurrences and actions required

3.15.2 Report witnessed and or experienced mistakes, near misses and errors

3.15.3 Adhere to instructions relevant to their treatment and follow up care

3.15.4 Communicate with the hospital regarding any safety concerns on their part

3.16 **Patient Safety Educational goals:**

3.16.1 Develop an educational program on how to reduce errors

3.16.2 Encourage reporting of errors and near misses

3.16.3 Departmental identification of risk factors within their scope and staff education on monitoring and limiting their effect on the hospital population

3.16.4 Staff responsibility and role in reporting of events

3.16.5 Root-cause analysis method for investigation and problem solving

3.17 **Selection of improvement priorities:**

3.17.1 Organizational improvement priorities are selected both proactively and in response to problems that are undefined through ongoing assessment of data and analysis of adverse event. Proactive selection of priorities occurs through the strategic planning process. This formal two-tired process, which includes an environmental assessment and assessment of the community needs, result in the indemnification of a three year global plan for the clinical enterprise as well as specific tactical plan to support the long-range plan. It is this tactical plan that drives the performance priorities. More specifically, the following sources of information are used to identify improvement opportunities

3.17.1.1 Strategic planning process: Benchmark internally and with other external comparative date.

3.17.1.2 Patient satisfaction data/ complaints:

3.17.1.3 Sentinel events

3.17.1.4 Occurrences

3.17.1.5 Other performance data.

3.17.2 Several clinical care management and functional have been selected as improvement priorities. The following is a list of the current clinical improvement and care management priorities:

3.17.2.1 Medication processes.

3.17.2.2 Medical records completeness.

3.17.2.3 Obstetrics care in the Emergency Department.

3.17.2.4 Adult ventilator days.

3.17.2.5 C- Section rates.

3.17.2.6 Operating Room efficiency.

3.17.2.7 Discharge planning.

3.17.2.8 Pain management.

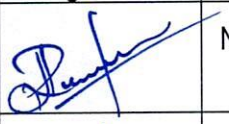
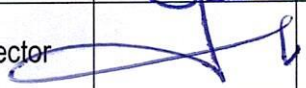
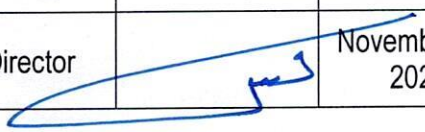
3.18 **QPS Program Education Plan:**

SL	Topic	Scope	Target Group	Frequency
1	Introduction to QM&PS	Lectures: General concepts and history.	Leadership, middle management and all staff	Twice a year
2	Strategic Planning	Workshops: and actual establishment of the strategic plan: Hospital plan, departmental plans	Administration then dept. heads	Every two months during establishment and annually for review
3.	SWOT ANALYSIS	Lectures and Workshop		
4	QI teams training	QM concepts, QI tools, application of FOCUS-PDCA	Departmental QI teams and	Twice a year or on as needed basis

		methodology, data utilization ...etc.	committee leaders/coordinators	
5	QI for Medical And Nursing Staff	Lecture and workshop on application of QM&PS in Medical and Nursing practice	Medical and Nursing staff (all levels)	
6	Multidisciplinary Teams (MDT) System	HGH MDT policy, teamwork and team building lecture	Committee chairpersons and other team leaders, department heads	Annually
7	QI week celebration	Lectures, workshops, quizzes, exhibition, etc.	All staff and other hospitals	Annually
8	Introductions to QM systems	To introduce the staff to QM systems when they are established (both administrative and Clinical)	All staff	Quarterly
9	Targeted lectures on: Accreditation process, Data utilization and Management, Supporting QI initiatives etc.	To discuss applications of QM&PS by various functions. To enable staff to connect their daily tasks to QM&PS concepts and tools.	Departmental and functional	
10	Patient Safety Goals	To orient on patient safety goals and discuss compliance monitoring	All staff	Quarterly

3.19 **Quality and Patient Safety Plan Evaluation**: The QM Plan of MCH shall be reviewed on annual basis at the end every year. The QMC shall be responsible for the review and the Quality and Patient Safety Advocacy department shall carry out communication of the updated plan. Department heads shall ensure communication of any changes and additions to the plan to their respective staff.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Rhodora Natividad	Document Management Control Coordinator		November 10, 2024
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		November 12, 2024
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		November 15, 2024
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		November 17, 2024
Approved by:	Mr. Fahad Hezam AlShammari	Hospital Director		November 14, 2024

Attachment A

THE PERFORMANCE IMPROVEMENT METHODOLOGY (TEMPLATE)

Use this template to plan your Quality improvement steps in accordance with the FOCUS-PDCA method

Fill the 1st section of this table (F & O) and discuss with QM&PS Dept regarding the execution of the study.

FOCUS

STEPS TO IDENTIFY AND DEFINE IMPROVEMENT OPPORTUNITIES - FOCUS	
F	**Find - an opportunity for improvement**
O	**Organize- a team**
C	**Clarify- The current process**
U	**Understand- the sources of the problem and the process variation**
S	**Select- The improvement**

THE PERFORMAI\CE IMPROVEMENT METHODOLOGY (TEMPLATE)

Use this template to plan your Quality improvement steps in accordance with the FOCUS-PDCA method

STEPS TO IDENTIFY AND DEFINE IMPROVEMENT OPPORTUNITIES - PDCA	
P	**Plan -the improvement**
D	**Do- the improvement**
C	**Check- the results**
A	**Act- To hold the gain**

Appendices

REFERENCE FOR MCH IMPLEMENTATION OF PATIENT SAFETY GOALS

(JOINT COMMISSION 2014 NATIONAL PATIENT SAFETY GOALS)

Safety Goal	Requirement	Implementation Expectations for Requirement
Goal 1: Identify patient correctly.	1A: Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other Treatments or procedures.	Two patient identifiers are used when doing following: 1.1 Administering medications or blood products 1.2 Collecting blood samples and other specimens for clinical testing. 1.3 The patient's room number or physical location is not used as an identifier. 1.4 Containers used for blood and other specimens are labeled in the presence of the patient. 1.5 Processes are established to maintain samples' identity throughout the pre-analytical, analytical and post-analytical processes.
	1B: Prior to the start of any invasive procedure, conduct a final verification process to confirm the correct patient or resident, procedure, site, and availability of appropriate documents. This verification process uses active-not passive-communication techniques.	The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure. The process must involve the entire operative team, use active communication, and must, at least, include the following: 2.1 Correct patient identity. 2.2 Correct side and site 2.3 Agreement on the procedure to be done. 2.4 Correct patient position. 2.5 Availability of correct implants and any special equipment or special requirements. The process is briefly documented, such as in a checklist. The organization has processes and systems in place for reconciling differences in staff responses during the final verification process. The patient's identity is re-established if the practitioner leaves the patient's location prior to initiating the procedure. Marking the site is required unless the practitioner is in continuous attendance from time of the decision to do the procedure and patient consent to the initiation of the procedure (for example, bone marrow collection, or fine needle aspiration).

Goal 2:		
Improve effective communication		1. The receiver of the information writes down the complete order or test result or enters it into a computer. 2. The receiver of the information reads the order back. 3. The receiver of the information receives confirmation from the individual who gave the order or test result.
	2A: For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result " read back" the complete order or test result.	1. The organization develops a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. 2. The list of abbreviations not to be used includes the following: 2.1 U, u 2.2 IU 2.3 Q.D., QD, q.d.,qd 2.4 Q.O.D., QOD, q.o.d, qod 2.5 Trailing zero (X.0 mg) 2.6 Lack of leading zero (.X mg) 2.7 MS 2.8 MSO4 2.9 MgSO4 3. The organization implements the "do not use" list and applies this list to all orders and all medication-related documentation when handwritten or entered as free text into a computer. 4. Preprinted forms do not include any abbreviations identified as not to be used.
	2B: Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.	
	2C: Measure, assess, and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.	1. The organization defines critical tests and critical results/values. 2. The organization defines the acceptable length of time between the ordering of critical tests and reporting the test results and values. 3. The organization defines the acceptable length of time between the availability of critical results/ values and receipt by the responsible licensed care giver. 4. The organization collects data on the timeliness of reporting critical results/values. 5. The organization assesses the data and determines whether there is a need for improvement. 6. The organization takes appropriate action to improve and measure the effectiveness of those actions. 7. Critically abnormal results are communicated quickly to a responsible individual so that prompt action may be taken. 8. When the responsible licensed caregiver is provided in a timely manner to another qualified responsible caregiver to prevent avoidable delays in treatment or response.

Goal 3: Improve the safety of high alert medication .	3B: Standardize and limit the number of drug concentrations available in the organization.	1. Standardize the drug concentrations used by the organization. 2. When more than once concentration of a drug is necessary, the number of concentrations are limited to the minimum required to meet patient care needs.
	3C: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.	1. Identify a list of look-alike/ sound-alike drugs used by the organization (the list must include a minimum of 10 look-alike/ sound-alike drug combinations). 2. Review the list of look-alike/ sound-alike drugs used by the organization at least annually. 3. The organization takes action to prevent errors involving the interchange of these drugs.
	3D: Label all medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.	1. Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used. 2. Labeling occurs when any medication or solution is transferred from the original packaging to another container. 3. Labels include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours. 4. All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication. 5. No more than one medication or solution is labeled at one time. 6. Any medications or solutions found unlabeled are immediately discarded. 7. All original containers from medications or solutions remain available for reference in the perioperative are until the conclusion of the procedure. 8. All labeled containers on the sterile field are discarded at the conclusion of the procedure. 9. At shift change or break relief, all medications and solutions both on and off the sterile field an their labels are reviewed by entering and exiting personnel.

Goal 4: Eliminate wrong site, Wrong patient, wrong procedure.	4A: Conduct a preoperative Verification process.	1. Verification of the correct patient, procedure, and site should occur during the following: 1.1 At the time the surgery/ procedure is scheduled. 1.2 At the time of admission or entry into the Hospital. 1.3 Anytime the responsibility for care of the patient is transferred to another caregiver. 1.4 With the patient involved, awake and aware if possible. 1.5 Before the patient leaves the preoperative area or enters the procedure/ surgical room. 2. The following is reviewed prior to the start of the procedure: 2.1 Relevant documentation (e.g. H&P, consent). 2.2 Relevant images properly labeled and displayed. 2.3 Any required implants and special equipment
	4B: Mark the operative site.	1. Make the mark at or near the incision site; do not mark any non-operative site(s) unless necessary for some other aspect of care. 2. The mark must be ambiguous (consider X as ambiguous). 3. The mark must be positioned to be visible after the patient is prepped and draped. 4. The method of marking and type of mark should be Consistent throughout the organization. 5. At a minimum. mark all cases involving laterality, multiple structures (fingers. toes, Lesions), or multiple levels (spine). 6. The person performing the procedure should do the site marking 7. Marking must take place with the patient involved, Awake and aware, if possible.
	4C: Conduct a "time out" immediately before starting the procedure.	1 The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure. 2 The process must involve the entire operative team, use active communication, and must, at least, include: 2.1 Correct patient identity 2.2 Correct side and site 2.3 Agreement on the procedure to be done 2.4 Correct patient position 2.5 Availability of correct implants and any special equipment or special requirements. 3 The process is briefly documented, such as in a checklist. 4 The organization should have processes and systems in place for reconciling differences in staff responses during the final verification process.

Goal 5: Reduce the risk of health care-acquired infections.	5A: Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.	1 In general, CDC hand hygiene guidelines require the staff to decontaminate hands with a hygienic hand rub or by washing with disinfectant soap before and after direct contact with a patient or objects immediately around a patient.
Goal 6: Reduce the risk of patient harm resulting from falls.	6A: Implement a fall reduction program and evaluate the effectiveness of the program.	1 The organization establishes a fall reduction program. 2 The fall reduction program includes an evaluation as appropriate to the patient population, settings and services provided. 3 The fall reduction program includes interventions to reduce the patient's fall risk factors. 4 Staff receives education and training for the fall reduction program. 5 The patient and patient's family is educated on the fall reduction program and any individualized fall reduction strategies. 6 The fall reduction program is evaluated to determine the effectiveness of the program. (Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.)
This Plan to be revised annually		