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(Updated 2/06)

Questions about goal #2 (Communication):

[2A] Whenever a nurse takes a telephone or verbal order in our hospital, he or she must repeat it back to the physician to confirm that it was understood correctly. Is this acceptable?
No. Simply repeating back the order is not sufficient. Whenever possible, the receiver of the order should write down the complete order or enter it into a computer, then read it back, and receive confirmation from the individual who gave the order.

[2A] Does this “read back” requirement also apply to physicians, such as when an attending gives a verbal or telephone order to a resident or when a nurse calls a test result to a physician?
Yes, it applies to all caregivers, including physicians. As it applies to communicating critical test results, Joint Commission will not survey the actual performance of this read-back activity in physicians’ offices, nor do we expect the organization to directly evaluate this in physicians’ offices. However, the organization should establish with its medical staff an expectation for “read-back” whenever receiving critical test results verbally, including over the telephone. Organization staff should request a “read-back” whenever communicating critical test results verbally, including over the telephone.

The intent of NPSG #2A is to ensure that orders and directives that would be carried out in a verbal or telephone order are clear to the recipient and confirmed by the individual giving the order. In addition, all verbal or telephone reports of diagnostic tests determined by the organization to be “critical” require a read-back.

“Read-back” is not required when these communications do not include verbal communication of orders or critical test values. The following situations give examples of when “read-back” is not required.
- Physician to physician consultation (ex: details of consultation is given by a radiologist to the primary physician).
- Dialogue between professionals (i.e. physician to physician – ex: orthopedic physician is giving details of a consultation to a peer or resident).

[Revised 04/10/04, Reviewed 9/05]

[2A] In an emergency situation such as a code in the ER, if the physician calls out the medication order and the RN repeats it back before administering the drug, and the code recorder is documenting the name of the drug, dose, time, route, and rate, is this acceptable?
Yes. In certain situations such as a code or in the OR, it may not be feasible to do a formal "read-back." In such cases, "repeat-back" is acceptable. [Reviewed 9/05]

[2A] Requirement 2A states: "Implement a process for taking verbal or telephone orders that require a verification "read back" of the complete order by the person receiving the order." How do you demonstrate that this occurs?
The Joint Commission has not established any documentation requirements for this goal. When we survey your compliance with the goals, we may ask how you track performance against the
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goal, i.e., how do you know that the process is being done consistently? Whatever your method is, which may or may not include some form of documentation, we will take this into consideration as we evaluate your performance based on your approach for tracking compliance. [Revised 2/06]

[2A] In our home care service, physicians or their agents frequently leave orders on nurse voice mail. Is this acceptable given the NPSG requirement for read back?
No. Voice mail orders are not acceptable within the context of the NPSGs. Also, most state laws require nurses and pharmacists to obtain the order directly from the prescriber or his/her agent. When not received directly, the nurse or pharmacist must call the prescriber back to get the order directly, including a “read-back.” [New 7/30/03, Reviewed 9/05]

[New—2A] We have recently heard of voice-mail systems that have been designed to support the “read-back” process. What is the Joint Commission’s position on such systems?
As noted above, the usual voice mail system is not acceptable under this NPSG requirement. However, if a system is designed such that all the steps in the read-back process, including the final confirmation that the read-back information is correct, can be accomplished in a time frame that meets the care needs of the patient, then it would be acceptable. We are not currently aware of such a system. [New 2/06]

[2A] In home care, there are times when the parent or other family member is the patient's primary caregiver. This leads to the family member receiving verbal or telephone orders from physicians when there is no nurse in the home at the time, then communicating the orders to the nurse when she arrives. Is this acceptable?
Patients or their family members are not considered physicians’ agents, nor are they qualified by law and regulation in most (if not all) states to receive orders for care. If, in a particular locality, this is legally permissible, then a “read-back” of any verbal or telephone order should be carried out, and the family member would have to be trained to do this. [New 7/30/03, Reviewed 9/05]

[2B] Many of the listed abbreviations can be used in upper or lower case, with or without periods after the letters. If “Q.D.” is on our “do not use” list, can “QD” or “qd” be used?
An abbreviation on the “do not use” list should not be used in any of its forms—upper or lower case; with or without periods. [New 11/3/03, Reviewed 9/05]

[New—2B] What is the expectation for clarifying orders that contain “do not use” abbreviations?
Any time an order is unclear, it must be clarified with the ordering practitioner. This is an explicit requirement of the Medication Management standards (MM.3.20, EP #5 and MM.4.10, EP #6) and is addressed more broadly for other types of orders in the Leadership standards (LD.3.60, EP #2). In the case of orders containing “do not use” abbreviations, the same requirements apply. That is, nurses and pharmacists exercise discretion to determine when an order is not clear and, in such cases, must contact the practitioner for clarification. [New, 2/06]
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[New—2B] There used to be an expectation that all orders containing “do not use” abbreviations must be clarified with the prescriber before implementing the order. Why was it changed?
While all of the terms on the Official “Do Not Use” List have been associated with misinterpretation resulting in medical errors and patient harm, the intended meaning of such a term in the context of a specific, individual order may or may not be clear and, therefore, may or may not require clarification by the prescriber. The requirement to eliminate the use of these terms is a significant and difficult change for many prescribers. Even with the best intentions and efforts, there will be occasional slips. For organizations in which there continues to be frequent use of prohibited abbreviations, the result has been a significant additional burden on nursing and pharmacy staff, reaction by some prescribers to what they perceive as unnecessary calls, and an unintended consequence of disrupted interdisciplinary collaboration and decreased responsiveness by prescribers to calls, especially from the pharmacy, leading to increased risk for patients. [New, 2/06]

[New—2B] What if some of our prescribers are unable or unwilling to stop using these prohibited terms or are unresponsive to calls from the pharmacy or other organization staff?
These are matters to be addressed and resolved by the medical staff. Organization leadership should work with its medical staff to eliminate the use of prohibited abbreviations. Nurses’ and pharmacists’ responses to the use of prohibited abbreviations should be guided by patient safety considerations, not by an assigned responsibility for monitoring and modifying prescriber behavior. It is not the responsibility of nurses or pharmacists to manage the behaviors of prescribers. Joint Commission standards assign to the medical staff the responsibility for overseeing the quality and safety of patient care, treatment, and services provided by practitioners privileged through the medical staff process and, in particular, providing leadership in activities related to patient safety and improving performance associated with significant departures from established patterns of clinical practice. [New, 2/06]

[New—2B] What is the impact of this change on scoring this safety goal or related standards?
This change in expectations for clarification of orders containing “do not use” abbreviations does not affect the scoring of NPSG requirement 2B. The scoring of that requirement has been and will continue to be based only on the actual use of the prohibited terms. Failure to contact the prescriber when there are concerns, issues, or questions about an order will be scored at MM.4.10 (EP #6) for medication orders or at LD.3.60 (EP #2) for other types of orders. Failure of the medical staff to exercise its responsibilities for oversight of the actions of practitioners privileged through the medical staff process is scored at standards MS.2.10 and MS.3.10. [New, 2/06]

[New—2B] Are there any monitoring requirements associated with this expectation for clarifying orders that are not clear?
Medication Management standard MM.8.10 and the Performance Improvement standards require measurement, assessment, and improvement activities related to identified risk points. The decision on which processes and risk points are to be monitored is left to the organization. However, because the accuracy of orders is so crucial to patient safety, organizations are
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encouraged to monitor implementation of their processes for responding to unclear orders. [New, 2/06]

[2B] In addition to a list of abbreviations, acronyms and symbols not to use, isn’t there also a requirement for an "Approved Abbreviations List?"
Actually, no. The last time the standards explicitly required a list of approved abbreviations was in 1991. The current requirement in the standards is the following:

Abbreviations, acronyms, and symbols are standardized throughout the organization and there is a list of abbreviations, acronyms, and symbols not to use. (IM.3.10, EP #2)

This has been generally (and historically) interpreted as meaning there should be a list of approved abbreviations, acronyms and symbols. However, if we acknowledge that the principle reason for the standardization is to protect patients from the effects of miscommunication, then the most effective means of achieving this intent may not be a comprehensive "approved list." That's why the NPSGs focus on the (shorter) list of abbreviations, acronyms, and symbols not to use, reasoning that it will be easier to change behavior with respect to a short list than a long one. Having said that, if you wish to develop an “approved abbreviations” list, or reference Stedman's or SNOMED or some other medical terminology resource, that is quite acceptable under the standards, but it is not required. [Revised 2/06]

[2C] What is meant by the term “critical test results?” Who decides?
Part of the confusion in interpreting requirement 2C has centered on the term “critical test result.” Are we talking about a test result that is critical or the result of a critical test or both? In implementing this requirement, an organization will need to make a distinction between "critical tests"--those tests which will always require rapid communication of the results, even if normal--and "critical results"--those findings (even if from routine tests), which will always require rapid communication of those results. The former are commonly identified as "stat" exams. An organization may define other types of tests that should always require rapid communication of results. In the case of these “critical tests” the time interval to be measured should be from ordering the test to reporting the result.

For "critical results," it may be useful for the organization to develop a list of the more common findings that warrant rapid communication (e.g., “panic values” or “red-line values”) and add "other results that are determined by the laboratorian, radiologist, or other diagnostician to be critical to the patient's subsequent treatment decisions." For these, since it won’t be known that the result is critical until the test is done, the ordering-to-testing time frame is not relevant. The key measurement here would be the time from identification of the critical result to the reporting of that result.

If a subset of “critical test results” is not defined by the organization, surveyors will consider all verbal or telephone reports of diagnostic tests to be “critical.” [Revised 10/27/03, Revised 9/05]

[2C] Is the term “critical test results” limited to laboratory tests?
No. The term “critical test results” applies to all diagnostic tests including imaging studies, electrocardiograms, laboratory tests and other diagnostic tests defined by the organization as “critical”. [Revised 9/05]
[2C & 2D—New] In 2005, requirement 2D for Laboratories was similar to requirement 2C, which applies to other types of accredited organizations, except that it said the critical test results must be reported “directly” to the responsible licensed caregiver. In 2006, the word “directly” is not there. What’s the story?
Notwithstanding the presence or absence of the word “directly,” the reporting of a critical test result to an authorized “agent” of the responsible licensed caregiver will meet the requirement if the organization can demonstrate that there will be no significant additional delays in getting the test result to the responsible licensed caregiver so that the patient can be promptly treated. This last part is particularly important since the objective of these requirements is to avoid any unnecessary delays in treatment. Reporting to an office staff person who can then immediately provide the information to the practitioner will be a common scenario. Reporting to a hospital unit nurse, who must then hunt down the practitioner while dealing with a number of other priorities, will be less likely to meet this requirement. The onus will be on the hospital to demonstrate through data collection and analysis that this routing of the critical test report will not delay treatment. [New 2/06]

[New—2E] What is a “hand-off” communication?
The phrase “hand-off communication” refers to a contemporaneous process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care. The information is usually about the patient’s current condition, ongoing treatment, recent changes in condition, and possible changes or complications to watch out for. Examples include nursing change-of-shift report; physician sign-out to a covering physician; anesthesia provider or circulating nurse report to the PACU staff; ED staff communication with staff at a receiving facility when a patient is transferred. [New 2/06]

[New—2E] What is meant by “standardizing” an approach to “hand off communication”?
This means your organization must define, communicate to staff, and implement a process in which information about patient care is communicated in a consistent manner. Standardization provides a means to educate staff about the process and helps support consistent implementation throughout the organization. A standardized approach should identify the following items:

- The “hand-off” situations that it applies to
- Who is, or should be, involved in the communication
- What information should be communicated, for example,
  - Diagnoses and current condition of the patient
  - Recent changes in condition or treatment
  - Anticipated changes in condition or treatment
  - What to watch for in the next interval of care
- Opportunities to ask and respond to questions
- When to use certain techniques (repeat-back; SBAR)
- What print or electronic information should be available

[New 2/06]

[New—2E] Our nursing staff prefers to audiotape the change-of-shift report. Is this acceptable?
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It is not our intent to prohibit the use of taped reports. However, this method will not be acceptable unless it includes an opportunity to ask clarifying questions and to receive answers in a time frame that is consistent with having complete and accurate information available to the patient’s caregivers when they are providing the care. A process that relies on the option to call a nurse from the previous shift at home if there are questions about the taped report will not meet this requirement due to the understandable reluctance to do this as routinely as the question would be asked if the nurse were available face-to-face. [New 2/06]

[New—2E] Does the “hand off” requirement apply to services like physical therapy where patients are seen only on the day shift? We have relied on the progress notes in the chart to “hand off” between therapists from one day to the next. Is this acceptable?
Requirement 2E does apply in this situation, but the relevant time frames are expanded so the details of the hand off process may vary from other hand off processes. However, whatever method is used, there must still be an opportunity to ask and get responses to questions. Using the chart notes as the medium for communicating patient-specific information between therapists is acceptable as long as the incoming therapist can get answers to any questions in a time frame that is consistent with safe care for the patient. [New 2/06]