COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Diagnostic Accreditation Program

ACCREDITATION STANDARDS

Patient Safety

Diagnostic Accreditation Program
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Introduction

Patient safety is fundamental to the delivery of quality diagnostic services and optimal patient outcomes. A priority for all medical imaging services is to ensure that procedures are safe, and a continuous effort is made to improve patient safety. Appropriate and sufficient resources should be allocated to support the service's implementation of patient safety priorities and goals.

Creating a culture of patient safety

No.		Description	Risk	Reference	Change
DPS1.0		**THE DIAGNOSTIC SERVICE CREATES A CULTURE OF PATIENT SAFETY AND MAKES PATIENT SAFETY A PRIORITY.**			
DPS1.1		**The activities of the diagnostic service ensure patient safety.**			
DPS1.1.2	**M**	There is a process for patients and their advocates to report concerns related to patient safety.	M		
DPS1.1.3	**M**	There are systems in place to ensure patient safety notices, alerts and other information is communicated.	M		
DPS1.1.4	**M**	Mechanisms are in place to address patient sensitivities and allergies. *Guidance: At a minimum, latex-free products are made available for both patients and staff (e.g. tourniquets, gloves, bandages).*	M		
DPS1.1.5	**M**	All patient safety issues are documented and investigated.	M		
DPS1.1.6	**M**	There is a procedure for reporting possible indications of non-accidental injuries, sexual abuse, or exploitation of adult and pediatric patients.	M		Revised
DPS1.1.7	**M**	There are processes in place to ensure effective and timely transfer of patient information between health-care providers at interface points (e.g. shift changes, patient discharge, movement to other departments, etc.).	M		

Patient identification

No.		Description	Risk	Reference	Change
DPS2.0		**POSITIVE PATIENT IDENTIFICATION PRECEDES COMMENCEMENT OF THE EXAMINATION OR PROCEDURE.**			
DPS2.1		**Patient identification is confirmed prior to a patient's examination or procedure by the individual(s) performing the examination or procedure.**			
DPS2.1.1	**M**	Patients are involved in the identification process to the fullest extent possible.	H		
DPS2.1.2	**M**	Positive patient identification is confirmed prior to commencing all procedures and examinations by the person(s) performing the examination or procedure.	C		
DPS2.1.3	**M**	At least two unique patient identifiers are used when verifying patient identification.	C		
DPS2.1.4	**M**	The individual performing the examination verifies the correct procedure and correct procedural site with the patient prior to commencing the examination.	H		
DPS2.1.5	**B**	The imaging service maintains a list of acceptable patient identifiers. *Guidance: Acceptable patient identifiers include the patient's first and last name and date of birth; or patient's first and last name and a unique personal identifier number (e.g. provincial health number).*			
DPS2.1.6	**M**	In-patients are identified with a wristband or service-approved alternative procedure.	H		
DPS2.1.7	**M**	Staff confirm that information on the wristband is consistent with verbal information provided by the patient.	H		
DPS2.1.8	**M**	Pediatric and other patients who cannot provide identification information are identified by a responsible adult.	H		
DPS2.1.9	**M**	Patient identity information discrepancies are resolved prior to performing the examination or procedure.	H		
DPS2.2		**There are methods in place to address situations where the identity of the patient is unknown.**			

No.		Description	Risk	Reference	Change
DPS2.2.1	**M**	An emergency identification method is used when the patient's identity is unknown. *Guidance: This may contain an alias name and a unique ID number such as a medical record number.*	H		
DPS2.2.2	**M**	The temporary patient identification is attached to the patient, and affixed on patient samples and images, as applicable.	H		
DPS2.2.3	**M**	The temporary patient identification is cross-referenced with the patient's name and ID number when that name and number becomes known.	H		

The universal protocol

No.		Description	Risk	Reference	Change
DPS3.0		**THE UNIVERSAL PROTOCOL IS CONDUCTED FOR ALL PATIENTS UNDERGOING INVASIVE PROCEDURES.** *Guidance: The universal protocol applies to invasive procedures that expose patients to harm, including procedures done in settings other than the operating room. Certain routine minor procedures such as venipuncture, peripheral (intravenous catheter) placement, insertion of nasogastric tube or foley catheter insertion are not within the scope of the universal protocol.* *The universal protocol consists of a series of three steps undertaken to protect patient safety and reduce the occurrence of errors, adverse events and critical incidents. The universal protocol consists of the following steps:* 1. *A pre-procedure verification process* 2. *Marking the procedural site* 3. *A final "time out" verification process immediately before the procedure* *Invasive procedures, especially those requiring general anesthesia or deep sedation, place patients at risk. Patient safety for patients undergoing these procedures can be enhanced by conducting the universal protocol to verify patient identity, procedure and site prior to commencing the procedure.*			
DPS3.1		**The imaging service has a policy and procedure in place for conducting the universal protocol.**			
DPS3.1.1	**M**	The imaging service assesses the risks associated with each invasive procedure performed to identify those that fall within the universal protocol. *Guidance: At a minimum, those procedures that require general anesthesia, deep sedation or consist of more than one possible procedural site (e.g. breast, kidneys, etc.) fall within the universal protocol.*	M		
DPS3.1.2	**M**	There is a policy that outlines the process for conducting the universal protocol.	M		
DPS3.1.3	**M**	The policy clearly specifies the procedures that fall within the universal protocol.	M		

No.		Description	Risk	Reference	Change
DPS3.2		**A pre-procedure verification process is conducted and documented for all procedures that fall within the universal protocol.** *Guidance: A pre-procedure verification enables the imaging service to ensure that the correct procedure is performed on the right person. During the pre-procedure verification process, the imaging service verifies that the necessary documentation and equipment are available, that they are correctly identified and labeled, and that they are consistent with the expectations of the patient and the procedure team. Any discrepancies must be reconciled prior to commencing the procedure.*			
DPS3.2.1	**M**	There is a process in place to verify the correct procedure, for the correct patient, at the correct site prior to the procedure commencing.	C		
DPS3.2.2	**M**	Pre-procedure verification includes confirmation of patient identification.	H		
DPS3.2.3	**M**	Pre-procedure verification includes review of the patient medical history.	H		
DPS3.2.4	**M**	Pre-procedure verification includes correctly labeled test results and reports as applicable (e.g. pathology and imaging reports).	H		
DPS3.2.5	**M**	Pre-procedure verification includes a signed consent for the correct procedure.	H		
DPS3.3		**The procedure site is marked prior to commencing procedures that fall within the universal protocol.** *Guidance: Marking the procedure site protects patients from potential wrong-site procedures, particularly when there is more than one possible location for a procedure. A consistent marking process for marking procedure sites should be used throughout the imaging service.*			
DPS3.3.1	**M**	Procedures that require marking of the site prior to the procedure are identified.	H		
DPS3.3.2	**M**	Patients are involved in the marking of the site if possible.	H		
DPS3.3.3	**M**	The procedure site is marked by the individual who is accountable for the procedure and who will be present when the procedure is performed.	H		
DPS3.3.4	**M**	The process for marking the site, and the type of mark, is used consistently throughout the imaging service.	M		
DPS3.3.5	**M**	There is a process in place to verify the site when patients refuse site marking or when it is not technically or anatomically possible to mark the site.	M		

No.		Description	Risk	Reference	Change
DPS3.4		**A time-out (final verification) is performed prior to procedures that fall within the universal protocol.** *Guidance: The time-out is an intentional pause in activity taken immediately prior to commencing the procedure to clearly communicate and verbally confirm the patient, procedure and site amongst all members of the procedure team. All questions and/or concerns must be addressed prior to commencing the procedure.*			
DPS3.4.1	**M**	A time-out is conducted immediately before starting the procedure.	H		
DPS3.4.2	**M**	The time-out is standardized and involves members of the procedure team.	H		
DPS3.4.3	**M**	During the time-out, the team verifies the patient identity.	H		
DPS3.4.4	**M**	During the time-out, the team verifies the procedure with the consent documentation.	H		
DPS3.4.5	**M**	During the time-out, the team verifies the procedure site with site marking, if applicable.	H		
DPS3.4.6	**M**	The completion of the time-out is documented.	H		

Medication management and administration

No.		Description	Risk	Reference	Change
DPS4.0		**THE DIAGNOSTIC SERVICE HAS METHODS IN PLACE TO ENSURE THAT MEDICATION IS MANAGED AND ADMINISTERED TO PATIENTS SAFELY AND EFFECTIVELY.** *Guidance: Examples of medications include analgesics, anesthetics, contrast agents, narcotics, sedatives, and intravenous solutions.*			
DPS4.1		**Medications are stored safely.**			
DPS4.1.1	**M**	Storage of medications complies with manufacturer's recommendations.	H		
DPS4.1.2	**M**	All stored medications are labeled with the contents, expiration date, and any warnings as applicable.	H		
DPS4.1.3	**M**	The imaging service regularly inspects all medication storage areas and medications.	M		
DPS4.1.4	**M**	There are policies and procedures for the appropriate disposal of unused and expired medications.	M		
DPS4.2		**The imaging service ensures that all medications are labeled.**			
DPS4.2.1	**M**	Medication containers are labeled with the medication name, strength and quantity when medications are prepared but not administered immediately.	C		
DPS4.2.2	**M**	All medications are labeled with the date prepared and the expiration date when prepared but not administered within 24 hours or when the expiration occurs in less than 24 hours.	H		
DPS4.2.3	**M**	Any medication containers found unlabeled are immediately discarded.	H		
DPS4.3		**The appropriateness of all medication orders is reviewed.**			
DPS4.3.1	**M**	Only authorized staff request medications.	H		
DPS4.3.2	**M**	Medication orders are reviewed for possible patient allergies or sensitivities.	C		
DPS4.3.3	**M**	Medication orders are reviewed for the appropriateness of the dose, frequency, and route of administration.	C		
DPS4.3.4	**M**	Medication orders are reviewed for potential contraindications and adverse interactions.	C		

No.		Description	Risk	Reference	Change
DPS4.3.5	**M**	All concerns, issues, or questions related to the appropriateness of a medication order are resolved with the prescriber and/or staff involved with the patient's care or services prior to administration.	C		
DPS4.4		**Medications are administered safely.**			
DPS4.4.1	**M**	Only medical practitioners and authorized staff obtain and administer medication.	C		
DPS4.4.2	**M**	Patient identity is verified prior to medication administration.	H		
DPS4.4.3	**M**	There is a process in place to select correct medications prior to administration, including identifying look-alike and sound-alike medications.	M		
DPS4.4.4	**M**	Prior to administration, the medication is visually inspected for color, clarity and expiration date.	H		
DPS4.4.5	**M**	All pharmacologic agents are prepared and administered as per manufacturer's specifications.	M		
DPS4.4.6	**M**	There is a procedure for multi-dosing medication that complies with infection control guidelines and manufacturer's recommendations.	H		
DPS4.4.7	**M**	There is a process in place to ensure the individual administering the medication verifies that the medication is administered at the proper time, in the prescribed dose, and by the correct route to the correct patient.	M		
DPS4.5		**Patients are monitored to ensure that medication(s) have been administered safely and effectively.**			
DPS4.5.1	**M**	Patients are monitored to assess the effectiveness of the medication(s) administered to them.	H		
DPS4.5.2	**M**	Patients are monitored for any potential side effects and/or adverse reactions resulting from medication administration.	H		
DPS4.5.3	**M**	Staff know how to respond to adverse drug events, significant drug reactions and medication errors.	H		
DPS4.5.4	**M**	Processes are in place to ensure the safety of patients prior to discharge or release from the diagnostic service after receiving medications.	H		
DPS4.5.5	**M**	Prior to discharge from the diagnostic service, the patient is monitored for a sufficient amount of time to ensure readiness for discharge after receiving medications. Readiness for discharge is documented in the medical record.	H		

Adverse events and critical incidents

No.		Description	Risk	Reference	Change
DPS5.0		**ADVERSE EVENTS, CRITICAL INCIDENTS AND NEAR MISSES ARE MANAGED APPROPRIATELY.**			
DPS5.1		**There are policies, procedures and practices for managing adverse events, critical incidents and near misses.**			
DPS5.1.1	**B**	Definitions of adverse events, critical incidents and near misses applicable to the diagnostic service are communicated to all staff.			
DPS5.1.2	**M**	Policies and procedures for addressing adverse events and critical incidents are documented and available to all staff.	M		
DPS5.1.3	**M**	All adverse events and critical incidents are documented.	H		
DPS5.1.4	**M**	Policies and procedures for reporting, investigating and making recommendations following a near miss are documented and available to staff.	M		
DPS5.1.5	**B**	There is a systematic process to investigate adverse events and critical incidents to determine multiple underlying contributing factors. *Guidance: The investigation process is appropriate for the magnitude of the problem and risk to patient or staff safety.*			
DPS5.1.6	**B**	There are policies, procedures and practices for disclosing information to patients following an adverse event or critical incident.			
DPS5.1.7	**B**	Staff know who to contact for advice or direction and are aware of their role during an adverse event or critical incident.			
DPS5.1.8	**B**	There is a defined process for reporting an adverse event or critical incident to the administration of the organization and to outside organizations.			
DPS5.1.9	**B**	Support and counselling are available to patients, their families and staff following an adverse event or critical incident.			
DPS5.2		**There is a process to determine and manage the medical significance of adverse events and critical incidents.**			
DPS5.2.1	**M**	All reported adverse events and critical incidents are immediately assessed by appropriate technical and medical staff to determine medical significance.	H		

No.		Description	Risk	Reference	Change
DPS5.2.2	**M**	The referring practitioner is informed in cases of medical significance.	H		
DPS5.2.3	**B**	Appropriate technical and medical staff assesses indications for halting further examinations and authorizing resumption of affected procedures.			
DPS5.2.4	**B**	Medical staff assess indications for withholding diagnostic reports and review already released reports for potential recall.			
DPS5.3		**Recommendations following an adverse event or critical incident are implemented to decrease the likelihood of recurrence.**			
DPS5.3.1	**B**	There are mechanisms in place for management to regularly track and trend aggregate data collected through the reporting process.			
DPS5.3.2	**M**	Changes made to the diagnostic service's systems and processes to prevent recurrence are documented.	M		
DPS5.3.3	**B**	Recommendations and changes implemented are communicated to relevant staff.			
DPS5.3.4	**B**	Changes implemented are continuously monitored and evaluated to ensure effectiveness.			

Medical emergency management

No.		Description	Risk	Reference	Change
DPS6.0		**THE IMAGING SERVICE HAS PROCEDURES IN PLACE TO HANDLE MEDICAL EMERGENCIES.**			
DPS6.1		**There are procedures to handle medical emergencies in a timely and effective manner.**			
DPS6.1.1	**M**	There is a medical emergency response protocol in place.	C		
DPS6.1.2	**M**	Staff are familiar with the procedure(s) for responding to medical emergencies.	H		
DPS6.1.3	**M**	Emergency call systems are available in-patient care areas. *Guidance: Facilities should conduct a risk assessment to determine what emergency call systems are required (e.g. patient washrooms, changing rooms, etc.).*	M		
DPS6.1.4	**M**	Staff know how to access emergency medical services.	H		
DPS6.1.5	**M**	Staff know how to access emergency equipment and supplies.	H		
DPS6.1.6	**M**	The facility identifies staff who respond to medical emergencies and provides training in the use of emergency equipment.	M		
DPS7.0		**EMERGENCY PROCEDURES, EQUIPMENT AND SUPPLIES ARE AVAILABLE TO ADDRESS MEDICAL EMERGENCIES RESULTING FROM HIGH-RISK PROCEDURES.** *Guidance: High-risk procedures include complex interventional procedures, TEE, stress examinations, and the administration of moderate sedation or general anesthesia. Having attending personnel trained and experienced in the use of emergency equipment and supplies is required to deal with a variety of complications that can arise during imaging procedures. Examples of patient complications include cardiac arrest, life-threatening hemorrhage, anaphylactic contrast reaction, vasovagal reactions, pneumothorax, and sedation-related respiratory compromise.*			
DPS7.1		**Emergency procedures, equipment and supplies are available to respond to a medical emergency resulting from a high-risk procedure.**			

No.		Description	Risk	Reference	Change
DPS7.1.1	**M**	A minimum of one medical and/or technical staff member has current CPR certification. *Guidance: Individuals with CPR certification are present during the procedure as defined by the service or facility protocol.*	M		
DPS7.1.2	**M**	Oxygen and suction equipment with appropriate delivery devices and attachments are readily available.	H		
DPS7.1.3	**M**	Drills to rehearse and refine medical emergency response protocols are performed to protect patients, staff and responders.	M		
DPS7.1.4	**M**	Emergency equipment and supplies are appropriate for the patient population (e.g. adults and pediatrics).	H		
DPS7.1.5	**M**	Emergency equipment and supplies are regularly inspected and maintained.	M		
DPS7.1.6	**M**	Emergency equipment and supplies are available.	C		
DPS7.1.7	**M**	Emergency drugs are available.	H		
DPS7.1.8	**M**	Emergency drugs are within expiry date.	H		
DPS7.1.9	**M**	Emergency drugs are secure.	H		

Patient immobilization

No.		Description	Risk	Reference	Change
					New
DPS8.0		**PATIENTS ARE IMMOBILIZED/RESTRAINED SAFELY**			
DPS8.1		**Immobilization devices and restraints are operated safely.**			
DPS8.1.1	**M**	All immobilizing devices are inspected for safety and cleanliness.	M		New
DPS8.1.2	**B**	There is a policy and procedure for the immobilization/restraint of patients.			New
DPS8.1.3	**M**	Infant/pediatric immobilizers are available and utilized for infant/pediatric imaging, as applicable.	M		New

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