




APPROVED: Revised Universal Protocol for 2010

Based on feedback from a recent field review, The Joint Commission revised the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™ for the **hospital, critical access hospital, ambulatory care, and office-based surgery** programs. While some changes will be **effective January 1, 2010**, others are **effective immediately**. For the remainder of 2009 on-site surveys, surveyors will not evaluate compliance with requirements that were eliminated but will review the EPs that were substantially modified. The following elements of performance (EPs) are affected:

- UP.01.01.01, EPs 1 and 2
- UP.01.02.01, EPs 1, 2, 3, and 7
- UP.01.03.01, EPs 1, 5, and 6

Given the diversity of organizations that need to follow the Universal Protocol, The Joint Commission intends for the revisions to address patient safety issues while allowing organizations flexibility in applying the requirements within existing work processes. The changes stem from concerns shared with The Joint Commission by accredited and professional organizations related to the practical implications of complying with modifications to the Universal Protocol that became effective January 1, 2009. These concerns focused primarily on the specificity of the requirements. An overview of the changes to the Universal Protocol appears in the box below. The revised Universal Protocol appears on pages 30 and 31 of this issue and on The Joint Commission Web site at <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>. 

Summary of Changes to the Universal Protocol for 2010

- **Applicability:** The Universal Protocol applies to “all surgical and non-surgical invasive procedures.” This is a change from “all invasive procedures that put patients at more than minimal risk, regardless of the location within an organization.”
- **Pre-procedure verification (UP.01.01.01):** References to the location (pre-procedure area) and timing of the verification have been removed. The term *checklist* implied the need to document each step for each patient and is now replaced by reference to a standardized list to be used in the verification process. A note has been added clarifying that documentation of the use of the standardized list on a per-patient basis is not required, although it is expected that the list be used for every patient.
- **Site marking (UP.01.02.01):** The revised Universal Protocol requires that the procedure site be 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 a *qualified* individual who is permitted by the organization to participate in the procedure, is familiar with the patient, and will be present when the procedure is performed, including residents qualified through a medical residency program, licensed advanced practice registered nurses (APRNs), and physician assistants (PAs) who perform duties requiring collaboration or supervisory agreements with a licensed independent practitioner. This option is available when it is not feasible for the person responsible for the procedure to mark the site and takes into account the current position of The Joint Commission, National Quality Forum, World Health Organization, and American Academy of Orthopaedic Surgeons and the concern raised by the field that the current requirement is impractical under some circumstances. The Joint Commission will continue to gather input and data on this issue.
- **Alternative processes for site marking (UP.01.02.01):** The current Universal Protocol describes situations in which exceptions to site marking are allowed. The requirement was modified to allow organizations to develop alternative processes for site marking.
- **Time-out (UP.01.03.01):** The time-out will occur prior to incision or the start of the procedure. References in the current Universal Protocol to conducting the time-out before the provision of anesthesia were removed. The rationale states that the organization may do the time-out before providing anesthesia or may choose to do more than one time-out. The list of issues to address in the time-out was shortened to focus on the correct patient, procedure, and site.