# The Joint Commission Quick Reference Guide for Medical Staff

**Provision of Care, Treatment and Services**

- History and physical must be completed, signed, dated, legible and in the medical record within 24 hours of admission and prior to any procedure.
- When supervising allied health professionals, physicians must co-sign their orders within 48 hours and make their own entry into the progress notes in addition to the allied health professional's notes.
- Post procedure notes must be dictated or written ***after*** the procedure is performed.
- When administering conscious sedation or anesthesia, you must conduct and document a pre-anesthesia/sedation assessment in the medical record prior to the procedure.

**Ethics, Rights and Responsibilities**

- Complete **Informed Consent** prior to procedures and orders for blood transfusions.
- Educate patient on the risks, benefits and alternatives to treatment and blood administration
- Attest to the informed consent and education process in the medical record.

**Information Management**

- Date and time all entries made in the medical record.
- Signature must be legible along with identification number on all entries in the medical record.
- Provide name and ID number to the nurse when giving telephone orders.
- Telephone orders must be electronically authenticated in Web/VS within 48 hrs.

**2008 National Patient Safety Goals**

**Medication Management**

- Use weight-based dosing when prescribing for pediatrics (unit/kg/dose).
- When ordering chemotherapy, use BSA (dose/m2/dose) and the total calculated dose.

**Patient Identification**

- Staff must use two patient identifiers during the provision of treatments, transfusions, medications or procedures. In our inpatient and outpatient procedural settings, the patient identifiers are name and medical record number. In all other outpatient settings, patients will be asked their name and date of birth.

**Improve Communication**

- Use CSMC-approved abbreviations.
- Respond to calls regarding critical values within 30 minutes.
- Allow nurse to record and read back orders while on telephone.

**Reduce the risk of healthcare-associated infections**

- Comply with all posted isolation/precautions signs when going in and out of patient rooms.
- Use sterile wide barriers for central line insertions.
- Ensure appropriate use and timing of antibiotics.

**Hand Hygiene**

Use alcohol hand-rub, or soap and water every time:

- Upon **entering** and **exiting** patient's room, or upon approaching and leaving patient's bedside in common areas such as the PACU, Procedure Center, etc.
- After removing gloves.
- After contact with patient's equipment or belongings.

**Universal Protocol**

- Use standardized pre-operative/procedure verification process in Pre-op to identify the correct patient, correct procedure and correct side/site, and to mark the operative site with the active participation of the patient.
- Use Universal Protocol – TIME OUT -- immediately before starting every procedure by confirming the correct patient, correct procedure, correct position, correct side/site and correct special equipment, with the entire team.