

National Patient Safety Goals

2006 Critical Access Hospital and Hospital National Patient Safety Goals

Note: New Goals and Requirements are indicated in **bold**.

- Goal 1 Improve the accuracy of patient identification.
 - 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.
 - 1B Not applicable.
- Goal 2 Improve the effectiveness of communication among caregivers.
 - 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.
 - 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.
 - 2D Not applicable.
 - 2E Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.**
- Goal 3 Improve the safety of using medications.
 - 3A Retired in 2006.
 - 3B Standardize and limit the number of drug concentrations available in the organization.
 - 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.
 - 3D Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.**
- Goal 4 Not applicable.
- Goal 5 Retired in 2006.
- Goal 6 Not applicable.
- Goal 7 Reduce the risk of health care-associated infections.
 - 7A Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
 - 7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.
- Goal 8 Accurately and completely reconcile medications across the continuum of care.

- 8A Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
- 8B A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.
- Goal 9 Reduce the risk of patient harm resulting from falls.
- 9B Implement a fall reduction program and evaluate the effectiveness of the program. **Note: Replacement for 9A**
- Goal 10 Not applicable.
- Goal 11 Not applicable.
- Goal 12 Not applicable.
- Goal 13 Not applicable.
- Goal 14 Not applicable.