

2007 – 2008 Patient Safety Goals

****Bold print in 3E, 16, & 16A signifies new for 2008****

- Goal 1 Improve the accuracy of patient identification.
- 1A Use at least two patient identifiers when providing care, treatment or services.
- 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 information record and "read-back" the complete order or test result.
- 2B Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.
- 2C Measure and 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.
- 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.
- 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.
- 3D Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.
- 3E Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.**
- Goal 7 Reduce the risk of health care-associated infections.
- 7A Comply with current [World Health Organization \(WHO\) Hand Hygiene Guidelines](#) or 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 There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.
- 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. The complete list of medications is also provided to the patient on discharge from the facility.
- Goal 9 Reduce the risk of patient harm resulting from falls.
- 9B Implement a fall reduction program including an evaluation of the effectiveness of the program.
- Goal 13 Encourage patients' active involvement in their own care as a patient safety strategy.
- 13A Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.
- Goal 15 The organization identifies safety risks inherent in its patient population.
- 15A The organization identifies patients at risk for suicide.
- Goal 16 Improve recognition and response to changes in a patient's condition.**
- 16A The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.**
- Eliminate wrong-site, wrong-patient, wrong procedure surgery.
- Goal
- Use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
 - Utilize a process to mark the surgical site and involve the patient in the marking process.

