

2009 National Patient Safety Goals

Critical Access Hospital Program

*Note: Changes to the Goals and Requirements are indicated in **bold**. Gaps in the numbering indicate that the Goal is inapplicable to the program or has been "retired," usually because the requirements were integrated into the standards.*

This year's new requirements (1C, 7C, 7D, 7E, 8B and 8D) and modified (3E) have a one-year phase-in period that includes defined expectations for planning, development and testing ("milestones") at 3, 6 and 9 months in 2009, with the expectation of full implementation by January 2010. See the Implementation Expectations for milestones.

Goal 1 Improve the accuracy of patient identification.

01.01 Use at least two patient identifiers when providing care, treatment or services.

03.01 Eliminate transfusion errors related to patient misidentification.

Goal 2 Improve the effectiveness of communication among caregivers.

01.01 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.

02.01 Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

03.01 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.

05.01 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.

03.01 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.

04.01 Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

05.01 Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
*NOTE: This requirement applies only to [organizations]s that provide anticoagulation therapy and/or long-term anticoagulation prophylaxis (for example, arterial fibrillation) **where the clinical expectation is that the [patient]'s laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations where short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the [patient]'s laboratory values for coagulation will remain within (or close to) normal values.***

Goal 7 Reduce the risk of health care-associated infections.

01.01 Comply with current **World Health Organization (WHO) Hand Hygiene Guidelines** or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

02.01 Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

03.01 Implement evidence-based practices to prevent health care associated infections due to multiple drug-resistant organisms in critical access hospitals.

04.01 Implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections.

05.01 Implement best practices for preventing surgical site infections.

Goal 8 Accurately and completely reconcile medications across the continuum of care.

01.01 A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

02.01 The complete and reconciled list of medications is communicated to the next provider of service and the communication is documented when a [patient] is referred to or transferred from one [organization] to another. Alternatively, when a [patient] leaves the [organization]'s care directly to his or her home, the complete and reconciled list of medications is provided to the [patient]'s known primary care provider, or the original referring provider, or a known next provider of service.

Note: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the [patient], and family as needed, the list of reconciled medications is sufficient.

03.01 When a patient leaves the organization's care, a complete and reconciled list of the patient's medications is provided directly to the patient, and the patient's family as needed, and the list is explained to the [patient and/or family].

04.01 In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

Goal 9 Reduce the risk of patient harm resulting from falls.

02.01 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.

01.01 Identify the ways patients and their families can report concerns about safety and encourage them to do so.

Goal 16 Improve recognition and response to changes in a patient's condition.

01.01 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.