

## 2005 Hospitals' National Patient Safety Goals

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

Goal: Improve the accuracy of patient identification.

- 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.**

Goal: Improve the effectiveness of communication among caregivers.

- 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.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- **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.**

Goal: Improve the safety of using medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.
- **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.**

Goal: Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

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

- Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

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

- **During 2005, for full implementation by January 2006, develop 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.**
- **A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.**

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

- **Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks.**