



2008 National Patient Safety Goals

ABBREVIATION KEY:

APPLIES TO **AMBULATORY CARE (AHC)**, **ASSISTED LIVING FACILITIES (ALF)**, **BEHAVIORAL HEALTH CARE (BHC)**, **CRITICAL ACCESS HOSPITAL (CAH)**, **DISEASE-SPECIFIC CARE (DSC)**, **HOME CARE (OME)**, **HOSPITAL (HAP)**, **INTEGRATED DELIVERY SYSTEMS (IDS)**, **LABORATORY (LAB)**, **LONG TERM CARE (LTC)**, **MANAGED CARE ORGANIZATIONS (MCO)**, **MEDICARE/MEDICAID-BASED LONG TERM CARE (LT2)**, **OFFICE-BASED SURGERY (OBS)**, AND **PREFERRED PROVIDER ORGANIZATIONS (PPO)**

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Note: *New language is indicated in underline; deleted text is shown in ~~strike through~~.*

Note: *Gaps in the numbering indicate that a Goal or requirement was “retired,” usually because the requirements were integrated into the standards.*

Goal 1

Improve the accuracy of [patient] identification.

(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

Requirement 1A (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

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

Rationale for Requirement 1A

Wrong-[patient] errors occur in virtually all aspects of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual.

Implementation Expectations for Requirement 1A

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Two [patient] identifiers are used when administering medications (AHC, ALF, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME: or blood products).

M A 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Two [patient] identifiers are used when collecting blood samples and other specimens for clinical testing.

M C 3. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Two [patient] identifiers are used when providing other treatments or procedures.

A 4. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The [patient’s] room number or physical location is not used as an identifier.

M A 5. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Containers used for blood and other specimens are labeled in the presence of the [patient].

A 6. (LAB) Processes are established to maintain a sample’s identity throughout the pre-analytical, analytical, and post-analytical processes.

Requirement 1B (ALF, LAB, LTC, LT2, OME)

Prior to the start of any (ALF, LTC, LT2, OME: surgical or) invasive procedure, conduct a final verification process (such as a “time-out”) to confirm the correct [patient], procedure and site, using active—not passive—communication techniques.

Implementation Expectations for Requirement 1B

A 1. (ALF, LAB, LTC, LT2, OME) The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

M A 2. (ALF, LAB, LTC, LT2, OME) The process must involve the entire team, use active communication, and must, at least, include the following:

- Correct [patient] identity
- Correct side and site (LAB: and availability of appropriate documents)
- Agreement on the procedure to be done
- Correct [patient] position
- Availability of correct implants and any special equipment or special requirements

A 3. (ALF, LAB, LTC, LT2, OME) The process is briefly documented, such as in a checklist.

Note: *The organizations should determine the type and amount of documentation.*

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A 4. (ALF, LAB, LTC, LT2, OME) The organization has processes and systems in place for reconciling differences in staff responses during the final verification process.

M C 5. (LAB) The patient's identity is re-established if the practitioner leaves the patient's location prior to initiating the procedure.

M C 6. (LAB) Marking the site is required unless the practitioner is in continuous attendance from the time of the decision to do the procedure and patient consent to the initiation of the procedure (for example, bone marrow collection, fine needle aspiration).

Goal 2

Improve the effectiveness of communication among caregivers.

(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LTC2, OBS, OME)

Requirement 2A (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LTC2, OBS, OME)

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.

Rationale for Requirement 2A

Ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved [patient] safety.

Implementation Expectations for Requirement 2A

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The receiver of the information **writes** down the complete order or test result or enters it into a computer.

M C 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The receiver of the information **reads** back the order or test result.

M C 3. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The receiver of the information **receives** confirmation from the individual who gave the order or test result.

Requirement 2B (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

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

Implementation Expectations for Requirement 2B

A 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization develops a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

A 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The list of abbreviations not to be used includes the following:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)*
- Lack of leading zero (.X mg)
- MS
- MSO₄
- MgSO₄

M C 3. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization implements the "do not use" list and applies this list to all orders and all medication-related documentation when handwritten or entered as free text into a computer.

A 4. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Preprinted forms do not include any abbreviations identified as not to be used.

Requirement 2C (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

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 tests and critical results and values.

Implementation Expectations for Requirement 2C

A 1. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization defines critical tests and critical results and values.

A 2. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization defines the acceptable length of time between the ordering of critical tests and reporting the critical tests and critical results and values.

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*** Exception** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

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A 3. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization defines the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed care giver.

A 4. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization collects data on the timeliness of reporting critical tests and critical results and values.

A 5. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization assesses the data and determines whether there is a need for improvement.

A 6. (AHC, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization takes appropriate action to improve and measure the effectiveness of those actions.

M C 7. (LAB) Critically abnormal results are communicated quickly to a responsible individual so that prompt action may be taken.

A 8. (LAB) When the responsible licensed caregiver is not available, a back-up reporting system can ensure the information is provided in a timely manner to another qualified responsible caregiver to prevent avoidable delays in treatment or response.

Requirement 2E (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

Rationale for Requirement 2E

The primary objective of a “handoff” is to provide accurate information about a [patient’s] care, treatment, and services, current condition and any recent or anticipated changes. The information communicated during a hand off must be accurate in order to meet [patient] safety goals.

(AHC, ALF, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME: In health care there are numerous types of [patient] handoffs, including but not limited to nursing shift changes; physicians transferring complete responsibility for a [patient]; physicians transferring on-call responsibility; temporary responsibility for staff leaving the unit for a short time; **(AHC, ALF, CAH, DSC, HAP, LAB, OBS, OME:** anesthesiologist report to post-anesthesia recovery room nurse; nursing and

physician hand off from the emergency department to inpatient units, different hospitals, nursing homes, and home health care; and critical laboratory and radiology results sent to physician offices.)

(BHC: In Behavioral Health organizations that provide twenty-four-hour care, treatment, or services, a number of handoffs may occur, such as from teacher to child care worker, at change of shift, or from clinical staff to program staff.)

Implementation Expectations (IEs) for Requirement 2E

The organization’s process for effective “handoff” communication includes the following (IEs 1–4):

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Interactive communications allowing for the opportunity for questioning between the giver and receiver of [patient] information

M C 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Up-to-date information regarding the [patient’s] care, treatment and services, condition and any recent or anticipated changes

M C 3. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) A process for verification of the received information, including repeat-back or read-back, as appropriate.

A 4. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) An opportunity for the receiver of the hand off information to review relevant [patient] historical data, which may include previous care, treatment, and services

M C 5. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Interruptions during handoffs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

Goal 3 **Improve the safety of using medications.** **(AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)**

Requirement 3B (AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)

~~Standardize and limit the number of drug concentrations used by the organization.~~

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Rationale for Requirement 3B

When medications are part of the [patient] treatment plan, appropriate management is critical to ensuring [patient] safety. The development of standardized and redundant systems has been shown to decrease errors and improve outcomes.

Implementation Expectations for Requirement 3B

A 1. (AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)

Standardize the drug concentrations used by the organization.

A 2. (AHC, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)

When more than one concentration of a drug is necessary, the number of concentrations are limited to the minimum required to meet [patient] care needs.

Requirement 3C (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME)

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.

Implementation Expectations for Requirement 3C

A 1. (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME)

Identify a list of look-alike/sound-alike (LASA) drugs used by the organization (the list must include a minimum of 10 LASA drug combinations selected from the tables of LASA drugs posted on the Joint Commission Web site).

A 2. (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME)

Review the list of look-alike/sound-alike drugs used by the organization at least annually.

A 3. (AHC, BHC, CAH, HAP, LTC, LT2, OBS, OME)

The organization takes action to prevent errors involving the interchange of these drugs.

Requirement 3D (AHC, CAH, HAP, OBS)

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

Rationale for Requirement 3D

This risk reduction activity is consistent with safe medication practices and addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings.

Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. Medications or

other solutions in unlabeled containers are unidentifiable.

This unsafe practice neglects basic principles of medication management safety yet has been routine in many organizations with respect to medications transferred to the sterile field.

Implementation Expectations for Requirement 3D

A 1. (AHC, CAH, HAP, OBS) Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.

A 2. (AHC, CAH, HAP, OBS) Labeling occurs when any medication or solution is transferred from the original packaging to another container.

A 3. (AHC, CAH, HAP, OBS) Labels include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.

M C 4. (AHC, CAH, HAP, OBS) All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

A 5. (AHC, CAH, HAP, OBS) No more than one medication or solution is labeled at one time.

A 6. (AHC, CAH, HAP, OBS) Any medications or solutions found unlabeled are immediately discarded.

M C 7. (AHC, CAH, HAP, OBS) All original containers from medications or solutions remain available for reference in the perioperative/procedural area until the conclusion of the procedure.

A 8. (AHC, CAH, HAP, OBS) All labeled containers on the sterile field are discarded at the conclusion of the procedure.

M C 9. (AHC, CAH, HAP, OBS) At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.

Requirement 3E (AHC, HAP, CAH, LTC, OBS, OME)

Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

Note: *This requirement applies only to organizations that provide anticoagulation therapy.*

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Rationale for Requirement 3E

Anticoagulation is a high-risk treatment that commonly leads to adverse drug events due to the complexity of dosing anticoagulation medications, monitoring their effects, and ensuring patient compliance with outpatient therapy. The use of standardized practices that include patient involvement can reduce the risk of adverse drug events associated with the use of heparin (unfractionated), low molecular weight heparin (LMWH), warfarin, and other anticoagulants.

Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing (“milestones”) at 3, 6, and 9 months in 2008, with the expectation of full implementation by January 1, 2009.

Implementation Expectations for Requirement 3E

A 1. (AHC, HAP, CAH, LTC, OBS, OME) As of April 1, 2008, the [organization]’s leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of Requirement 3E.

A 2. (AHC, HAP, CAH, LTC, OBS, OME) As of July 1, 2008, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of Requirement 3E by January 1, 2009.

A 3. (AHC, HAP, CAH, LTC, OBS, OME) As of October 1, 2008, pilot testing of the process in at least one clinical unit is under way.

A 4. (AHC, HAP, CAH, LTC, OBS, OME) As of January 1, 2009, the process is fully implemented across the organization.

The Implementation Expectations (IEs) that will apply beginning January 1, 2009, are provided below (IEs 1–11).

Implementation Expectations for 3E

A 1. (AHC, HAP, CAH, LTC, OBS, OME) The organization implements a defined anticoagulant management program to individualize the care provided to each patient receiving anticoagulant therapy.

A 2. (AHC, HAP, CAH, LTC, OBS, OME) To reduce compounding and labeling errors, the organization uses ONLY oral unit dose products and pre-mixed infusions when these products are available.

M C 3. (AHC, HAP, CAH, LTC, OBS, OME) When pharmacy services are provided by the organization, warfarin is dispensed for each patient in accordance with established monitoring procedures.

M C 4. (AHC, HAP, CAH, LTC, OBS, OME) The organization uses approved protocols for the initiation and maintenance of anticoagulation therapy appropriate to the medication used, to the condition being treated, and to the potential for drug interactions.

M A 5. (AHC, HAP, CAH, LTC, OBS, OME) For patients being started on warfarin, a baseline International Normalized Ratio (INR) is available, and for all patients receiving warfarin therapy, a current INR is available and is used to monitor and adjust therapy.

M C 6. (AHC, HAP, CAH, LTC, OBS, OME) When dietary services are provided by the organization, the service is notified of all patients receiving warfarin and responds according to its established food/drug interaction program.

A 7. (AHC, HAP, CAH, LTC, OBS, OME) When heparin is administered intravenously and continuously, the organization uses programmable infusion pumps.

M C 8. (AHC, HAP, CAH, LTC, OBS, OME) The organization has a policy that addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.

M C 9. (AHC, HAP, CAH, LTC, OBS, OME) The organization provides education regarding anticoagulation therapy to (CAH, HAP: prescribers,) staff, patients, and families.

M C 10. (AHC, HAP, CAH, LTC, OBS, OME) Patient/family education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions.

A 11. (AHC, HAP, CAH, LTC, OBS, OME) The organization evaluates anticoagulation safety practices (see Standard MM.8.10).

Goal 7

Reduce the risk of health care–associated infections.

(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

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Requirement 7A (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines (**BHC**: when providing services to a high-risk population or administering physical care).

Rationale for Requirement 7A

Compliance with the WHO Hand Hygiene Guidelines or CDC hand hygiene guidelines will reduce the transmission of infectious agents by staff to [patients], thereby decreasing the incidence of health care–associated infections.

Implementation Expectation for Requirement 7A

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) Comply with current WHO Hand Hygiene Guidelines or CDC hand hygiene guidelines* (**BHC**: when providing services to a high-risk population, or administering physical care).

Requirement 7B (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

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

Rationale for Requirement 7B

A significant percentage of [patients] who unexpectedly die or suffer major permanent loss of function have health care–associated infections. These unanticipated deaths and injuries meet the definition of a sentinel event and, therefore, are required to undergo a root cause analysis. The root cause analysis should attempt to answer the questions (1) why did the [patient] acquire an infection and, (2) given the fact of the infection, why did the [patient] die or suffer permanent loss of function?

Implementation Expectations Requirement 7B

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization manages all identified cases of unanticipated death or major permanent loss of function associated with a health care–associated infection as sentinel events (that is, conducts a root cause analysis).

A 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The root cause analysis addresses the management of the [patient] before and after the identification of infection.

* Organizations are required to comply with all 1A, 1B, and 1C CDC or WHO guidelines.

Goal 8

Accurately and completely reconcile medications across the continuum of care. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)

Requirement 8A (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)

There is a process for comparing the [patient's] current medications with those ordered for the [patient] while under the care of the organization.

Rationale for Requirement 8A

[Patients] are most at risk during transitions in care (hand-offs) across settings, services, providers, or levels of care. The development, reconciliation and communication of an accurate medication list throughout the continuum of care is essential in the reduction of transition-related adverse drug events.

Implementation Expectations for Requirement 8A

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The organization, with the [patient's] involvement, creates a complete list of the [patient's] current medications at admission/entry.

M C 2. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The medications ordered for, administered to, or dispensed to the [patient] while under the care of the organization are compared to those on the list and any discrepancies (for example, omissions, duplications, potential interactions) are resolved.

Requirement 8B (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME)

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 organization.

Implementation Expectations for Requirement 8B

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The [patient's] accurate medication reconciliation list (complete with medications prescribed by the first provider of service) is communicated to the next provider of service, whether it be within or outside the organization

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M C 2. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The next provider of service checks the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.

M C 3. (AHC, ALF, BHC, CAH, DSC, HAP, LTC, LT2, OBS, OME) The complete list of medications is also provided to the [patient] on discharge from the organization.

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

(ALF, CAH, DSC, HAP, LTC, LT2, OME)

Requirement 9B (ALF, CAH, DSC, HAP, LTC, LT2, OME)
Implement a fall reduction program including an evaluation of the effectiveness of the program.

Rationale for Requirement 9B

Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate each [patient's] risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening, walking aids, assistive technologies and protective devices assessment, and environmental assessments.

Implementation Expectations for Requirement 9B

A 1. (ALF, CAH, DSC, HAP, LTC, LT2, OME) The organization establishes a fall reduction program.

M C 2. (ALF, CAH, DSC, HAP, LTC, LT2, OME) The fall reduction program includes an evaluation as appropriate to the [patient] population, settings, and services provided.

A 3. (ALF, CAH, DSC, HAP, LTC, LT2, OME) The fall reduction program includes interventions to reduce the [patient]'s fall risk factors.

M C 4. (ALF, CAH, DSC, HAP, LTC, LT2, OME) Staff receive education and training for the fall reduction program.

M C 5. (ALF, CAH, DSC, HAP, LTC, LT2, OME) The [patient] and [patient]'s family are educated on the fall reduction program and any individualized fall reduction strategies.

A 6. (ALF, CAH, DSC, HAP, LTC, LT2, OME) The fall reduction program is evaluated to determine the effectiveness of the program.

Note: *Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.*

Goal 10 Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.

(ALF, DSC, LTC, LT2)

Requirement 10A (ALF, DSC, LTC, LT2)

Develop and implement a protocol for administration and documentation of the flu vaccine.

Rationale for Requirement 10A

Influenza and pneumonia combined represent the fifth leading cause of death in the elderly. Along with the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), the Joint Commission promotes the administration of influenza and pneumococcal vaccines to adult residents in long term care and assisted living facilities and disease-specific care programs.

Implementation Expectations for Requirement 10A

A 1. (ALF, DSC, LTC, LT2) Appropriate protocols are developed to determine whether or not to administer the flu vaccine to a [patient].

M C 2. (ALF, DSC, LTC, LT2) There is evidence that protocols were implemented for residents identified as high risk.

Requirement 10B (ALF, DSC, LTC, LT2)

Develop and implement a protocol for administration and documentation of the pneumococcus vaccine.

Implementation Expectations for Requirement 10B

A 1. (ALF, DSC, LTC, LT2) Appropriate protocols are developed to determine whether or not to administer the pneumococcus vaccine to a [patient].

M C 2. (ALF, DSC, LTC, LT2) There is evidence that protocols were implemented for [patients] identified as high risk.

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Requirement 10C (ALF, DSC, LTC, LT2)

Develop and implement a protocol to identify new cases of influenza and to manage an outbreak.

Implementation Expectations for Requirement 10C

A 1. (ALF, DSC, LTC, LT2) Protocols are developed to identify cases of influenza and to manage an outbreak.

M C 2. (ALF, DSC, LTC, LT2) There is evidence the protocols were followed for [patients] displaying signs and symptoms of influenza.

A 3. (ALF, DSC, LTC, LT2) There is evidence the outbreak was managed (or identified) and tracked.

Goal 11

Reduce the risk of surgical fires.

(AHC, OBS)

Requirement 11A (AHC, OBS)

Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels with enough time for [patient] preparation, and establish guidelines to minimize oxygen concentration under drapes.

Rationale for Requirement 11A

When surgical fires occur, they often result in serious injury and sometimes death. The unique circumstances in the surgical environment (oxygen-rich atmosphere, flammable materials, and ignition sources) require response and prevention strategies to be specific to the setting. Educating surgical staff to these distinctions is crucial in reducing/eliminating surgical fires.

Implementation Expectations for Requirement 11A

A 1. (AHC, OBS) Organizations assess the risk for surgical fires based on equipment and procedures used.

A 2. (AHC, OBS) The organization establishes guidelines to minimize oxygen concentrations under drapes.

M C 3. (AHC, OBS) Organizations that identify themselves at risk provide staff training on methods to minimize oxygen concentration under drapes.

M C 4. (AHC, OBS) Organizations that identify themselves at risk provide staff training on methods to avoid the use of flammable solutions and materials.

M C 5. (AHC, OBS) Organizations that identify themselves at risk provide staff training on actions to take in the event of a surgical fire.

Goal 12

Implementation of applicable National Patient Safety Goals and associated requirements by components and practitioner sites.

(IDS, MCO, PPO)

Requirement 12A (IDS, MCO, PPO)

Inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements.

Implementation Expectation for Requirement 12A

M C 1. (IDS, MCO, PPO) Organizations inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements.

Goal 13

Encourage [patients]' active involvement in their own care as a [patient] safety strategy.

(AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

Requirement 13A (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME)

Define and communicate the means for [patients] and their families to report concerns about safety and encourage them to do so.

Rationale for Requirement 13A

Communication with [patients] and families about all aspects of their care, treatment, or services is an important characteristic of a culture of safety. When [patients] know what to expect, they are more aware of possible errors and choices. [Patients] can be an important source of information about potential adverse events and hazardous conditions.

Implementation Expectations for Requirement 13A

M C 1. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) [Patients] and families are educated on methods available to report concerns related to care, treatment, services, and [patient] safety issues.

M C 2. (AHC, ALF, BHC, CAH, DSC, HAP, LAB, LTC, LT2, OBS, OME) The organization encourages [patient]s and their families to report concerns about safety.

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Goal 14 Prevent health care–associated pressure ulcers (decubitus ulcers). (LTC, LT2)

Requirement 14A (LTC, LT2)

Assess and periodically reassess each [patient]’s risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks.

Rationale for Requirement 14A

Pressure ulcers (decubiti) continue to be problematic in all health care settings. Estimates are that 1.3 to 3 million adults have a pressure ulcer. The cost of treatment is \$500 to \$40,000 per ulcer. The incidence of pressure ulcer is from 2.2% to 23.9% in long term care and 0% to 17% in home care. Most pressure ulcers can be prevented and deterioration at Stage I can be halted. The use of clinical practice guidelines can effectively identify [patients] and define early intervention for prevention of pressure ulcers.

Implementation Expectations for Requirement 14A

A 1. (LTC, LT2) There is a plan for the prediction, prevention, and early treatment of pressure ulcers, which addresses:

- Identifying individuals at risk and the specific factors placing them at risk.
- Maintaining and improving tissue tolerance to pressure in order to prevent injury.
- Protecting against the adverse effects of external mechanical forces.
- Reducing the incidence of pressure ulcers through staff education programs.

M C 2. (LTC, LT2) Initial assessments are performed at admission.

M C 3. (LTC, LT2) A systematic risk assessment is conducted using a validated risk assessment tool such as the Braden Scale or Norton Scale.

M C 4. (LTC, LT2) Pressure ulcer risk is reassessed at periodic intervals.

M C 5. (LTC, LT2) Action is taken to address any identified risks.

Goal 15 The organization identifies safety risks inherent in its [patient] population. (BHC, HAP, OME)

Rationale for Goal 15 (BHC, HAP, OME)

Probabilistic risk assessment has been used to assess the designs of high-hazard systems such as chemical engineering plants and space initiatives. Probabilistic risk assessment looks at events that contributed to adverse outcomes. Health care has the ability to identify those areas of high-risk potential based on previous sentinel events and other data.

Requirement 15A (BHC, HAP)

The organization identifies [patients] at risk for suicide.

(HAP: Note: This requirement only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.)

Rationale for Requirement 15A

Suicide ranks as the eleventh most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #1 most frequently reported type of sentinel event since the inception of the Joint Commission’s Sentinel Event Policy in 1996. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important first step in protecting and planning the care of these at-risk individuals.

Implementation Expectations for Requirement 15A

M C 1. (BHC, HAP) The risk assessment includes identification of specific factors and features that may increase or decrease risk for suicide.

M C 2. (BHC, HAP) The [patient]’s immediate safety needs and most appropriate setting for treatment are addressed.

M C 3. (BHC, HAP) The organization provides information such as a crisis hotline to individuals and their family members for crisis situations.

Requirement 15B (OME)

The organization identifies risks associated with long-term oxygen therapy such as home fires.

Rationale for Requirement 15B

Nearly 43 percent of all sentinel events reported by home

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care programs to the Joint Commission were due to a fire in the [patient]'s home. Since April 1997, 11 sentinel events were received and reviewed by the Joint Commission related to home health care [patients] who were either injured or killed as a result of a fire in the home. In each case home oxygen was in use.

Implementation Expectations for Requirement 15B

- M C 1. (OME)** The home safety risk assessment includes presence or absence and working order of smoke detectors, fire extinguishers and fire safety plans, and review of all medical equipment.
- M C 2. (OME)** The organization provides education to the [patient] and family regarding causes of fire and fire prevention activities.
- M C 3. (OME)** The organization assesses the [patient]'s level of comprehension and compliance and reports any concerns to the [patient]'s physician.

Goal 16

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

(CAH, HAP)

Requirement 16A (CAH, HAP)

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.

Rationale for Requirement 16A

A significant number of critical inpatient events are preceded by warning signs for an average of 6 to 8 hours. Critical events such as cardiopulmonary and respiratory arrests or changes in patient's vital signs are estimated to occur in 4% to 17% of inpatient admissions. Early response by a specially trained individual(s) to changes in a patient's condition may reduce cardiopulmonary arrests and patient mortality.

Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing ("milestones") at 3, 6, and 9 months in 2008, with the expectation of full implementation by **January 1, 2009.**

Implementation Expectations for Requirement 16A

A 1. (CAH, HAP) As of April 1, 2008, the [organization]'s leadership has assigned responsibility for oversight and coordination

of the development, testing, and implementation of Requirement 16A.

A 2. (CAH, HAP) As of July 1, 2008, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of Requirement 16A by January 1, 2009.

A 3. (CAH, HAP) As of October 1, 2008, pilot testing of the process in at least one clinical unit is under way.

A 4. (CAH, HAP) As of January 1, 2009, the process is fully implemented across the organization.

The Implementation Expectations (IEs) that will apply beginning January 1, 2009, are provided below (IEs 1–6).

Implementation Expectations for Requirement 16A

A 1. (CAH, HAP) The organization selects an early recognition and response method most suitable for its needs and resources.

A 2. (CAH, HAP) The organization develops criteria for calling additional assistance to respond to a change in patient's condition or perception of change by the staff, patients, and families.

A 3. (CAH, HAP) The organization empowers staff, patients, and families to request additional assistance when they have a concern about the patient's condition.

M C 4. (CAH, HAP) Formal education for urgent response policies and practices is conducted with the people who may request assistance and the people who may respond to those requests.

A 5. (CAH, HAP) The organization measures the utility and effectiveness of the intervention(s) employed.

A 6. (CAH, HAP) The organization measures cardiopulmonary arrest, respiratory arrest, and mortality rates before and after implementation of an early intervention plan.

Universal Protocol

(AHC, CAH, DSC, HAP, OBS)

Wrong site, wrong procedure, wrong person surgery can be prevented. This universal protocol is intended to achieve that goal. It is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is

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endorsed by more than 40 professional medical associations and organizations.

In developing this protocol, consensus was reached on the following principles:

- Wrong site, wrong procedure, wrong person surgery can and must be prevented.
- A robust approach—using multiple, complementary strategies—is necessary to achieve the goal of eliminating wrong site, wrong procedure, wrong person surgery.
- Active involvement and effective communication among all members of the surgical team is important for success.
- To the extent possible, the patient (or legally designated representative) should be involved in the process.
- Consistent implementation of a standardized approach using a universal, consensus-based protocol will be most effective.
- The protocol should be flexible enough to allow for implementation with appropriate adaptation when required to meet specific patient needs.
- A requirement for site marking should focus on cases involving right/left distinction, multiple structures (fingers, toes), or levels (spine).
- The universal protocol should be applicable or adaptable to all operative and other invasive procedures that expose patients to harm, including procedures done in settings other than the operating room.

In concert with these principles, the following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, wrong person surgery:

- Pre-operative verification process
 - **Purpose:** To ensure that all the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.
 - **Process:** An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative

preparation of the patient, up to and including the "time-out" just before the start of the procedure.

- Marking the operative site
 - **Purpose:** To identify unambiguously the intended site of incision or insertion.
 - **Process:** For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.
- "Time-out" immediately before starting the procedure
 - **Purpose:** To conduct a final verification of the correct patient, procedure, site, and, as applicable, implants.
 - **Process:** Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a "fail-safe" mode, that is, the procedure is not started until any questions or concerns are resolved.

Universal Protocol 1 The organization fulfills the expectations set forth in the Universal Protocol. (AHC, CAH, DSC, HAP, OBS)

UP Requirement 1A (AHC, CAH, DSC, HAP, OBS)

Conduct a pre-operative verification process as described in the Universal Protocol.

Implementation Expectations for UP Requirement 1A

Ⓜ A 1. (AHC, CAH, DSC, HAP, OBS) Verification of the correct person, procedure, and site should occur during the following (as applicable):

- At the time the surgery/procedure is scheduled
- At the time of admission or entry into the facility
- Anytime the responsibility for care of the patient is transferred to another caregiver
- With the patient involved, awake and aware, if possible
- Before the patient leaves the preoperative area or enters the procedure/surgical room

Ⓜ A 2. (AHC, CAH, DSC, HAP, OBS) The following is reviewed prior to the start of the procedure:

- Relevant documentation (for example, history and physical, consent)

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- Relevant images, properly labeled and displayed
- Any required implants and special equipment

UP Requirement 1B (AHC, CAH, DSC, HAP, OBS)

Mark the operative site as described in the Universal Protocol.

Implementation Expectations for UP Requirement 1B

M C 1. (AHC, CAH, DSC, HAP, OBS) Make the mark at or near the incision site; do not mark any non-operative site(s) unless necessary for some other aspect of care.

A 2. (AHC, CAH, DSC, HAP, OBS) The mark must be unambiguous.

Note: For example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous.

M C 3. (AHC, CAH, DSC, HAP, OBS) The mark must be positioned to be visible after the patient is prepped and draped.

A 4. (AHC, CAH, DSC, HAP, OBS) The method of marking and type of mark should be consistent throughout the organization.

M C 5. (AHC, CAH, DSC, HAP, OBS) At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.

M C 6. (AHC, CAH, DSC, HAP, OBS) The person performing the procedure should do the site marking.

M C 7. (AHC, CAH, DSC, HAP, OBS) Marking must take place with the patient involved, awake and aware, if possible.

UP Requirement 1C (AHC, CAH, DSC, HAP, OBS)

Conduct a “time-out” immediately before starting the procedure as described in the Universal Protocol.

Implementation Expectations for UP Requirement 1C

M C 1. (AHC, CAH, DSC, HAP, OBS) The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

M A 2. (AHC, CAH, DSC, HAP, OBS) The process must involve the entire operative team, use active communication, and must, at least, include the following:

- Correct [patient] identity
- Correct side and site
- Agreement on the procedure to be done
- Correct [patient] position
- Availability of correct implants and any special equipment or special requirements

M C 3. (AHC, CAH, DSC, HAP, OBS) The process is briefly documented, such as in a checklist.

Note: The organization should determine the type and amount of documentation.

A 4. (AHC, CAH, DSC, HAP, OBS) The organization should have processes and systems in place for reconciling differences in staff responses during the final verification process.

Guidelines for the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™ (AHC, CAH, DSC, HAP, OBS)

These guidelines provide detailed implementation requirements, exemptions and adaptations for special situations.

1. Pre-operative verification process

Verification of the correct person, procedure, and site should occur (as applicable):

- At the time the surgery/procedure is scheduled
- At the time of admission or entry into the facility
- Anytime the responsibility for care of the patient is transferred to another caregiver
- With the patient involved, awake and aware, if possible
- Before the patient leaves the preoperative area or enters the procedure/surgical room

A preoperative verification checklist may be helpful to ensure availability and review of the following, prior to the start of the procedure:

- Relevant documentation (for example, history and physical, consent)
- Relevant images, properly labeled and displayed
- Any required implants and special equipment

2. Marking the operative site

- Make the mark at or near the incision site. Do NOT mark any non-operative site(s) unless necessary for some other aspect of care.
- The mark must be unambiguous (for example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous).

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- The mark must be positioned to be visible after the patient is prepped and draped.
- The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.
- The method of marking and type of mark should be consistent throughout the organization.
- At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

Note: *In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.*

- The person performing the procedure should do the site marking.
- Marking must take place with the patient involved, awake and aware, if possible.
- Final verification of the site mark must take place during the “time-out.”
- A defined procedure must be in place for patients who refuse site marking.

Exemptions:

- Single organ cases (for example, Cesarean section, cardiac surgery)
- Interventional cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization)
- Teeth—BUT, indicate operative tooth name(s) on documentation OR mark the operative tooth (teeth) on the dental radiographs or dental diagram
- Premature infants, for whom the mark may cause a permanent tattoo

3. “Time-out” immediately before starting the procedure

Must be conducted in the location where the procedure will be done, just before starting the procedure. It must involve the entire operative team, use active communication, be briefly documented, such as in a checklist (the organization should determine the type and amount of documentation) and must, at the least, include the following:

- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of correct implants and any special equipment or special requirements

The organization should have processes and systems in place for reconciling differences in staff responses during the “time-out.”

4. Procedures for non-OR settings including bedside procedures

- Site marking must be done for any procedure that involves laterality, multiple structures or levels (even if the procedure takes place outside of an OR).
- Verification, site marking, and “time-out” procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.
- Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through the conduct of the procedure may be exempted from the site marking requirement. The requirement for a “time-out” final verification still applies.