

2009 Patient Safety Goals Status Report:

GOAL	Status
I. Improve the accuracy of patient identification	
A. Use of 2 patient identifiers	Completed in 2007
B. NA	NA
C. Eliminating transfusion errors related to patient misidentification	DMH requires 2 qualified staff to conduct the identification verification process for patient requiring blood transfusions
II. Improve the effectiveness of communication among caregivers	
A. Reading back verbal orders	Completed in 2007
B. Creating a list of abbreviations not to use	Completed in 2004
C. Timely reporting of critical test and critical results	Completed in 2008
D. NA	NA
E. Managing hand-off communication	Completed in 2008
III. Improving the safety of using medications	
A. NA	NA
B. NA	NA
C. Managing look alike, sound alike medications	Completed in 2007
D. Labeling medication	Completed in 2008
E. Reducing harm from anticoagulation therapy	Team established in 2008 to work on the elements of performance. Policies have been written for patients receiving Warfarin. Currently working on unit dosing and improving patient and family education regarding anticoagulation therapy.
IV. NA	
V. NA	
VI. NA	
VII. Reduce the risk of healthcare associated infections	
A. Meeting hand hygiene guidelines	Completed 2007
B. Sentinel Events resulting from infection	Completed 2007
C. Preventing Multi-Drug Resistant Organism infections	Team established in 2008 to assist with decreasing MDRO infections. Infection Control currently monitors infections by type and number using

	evidenced-based guidelines.
D. Preventing Central-Line associated blood stream infections	Team established in 2008. Central blood stream infection monitoring was initiated in 2008 according to best practice guidelines.
E. Preventing surgical site infections	Team established in 2008. DMH participates in the CMS SCIP measures monitoring surgical site-infections since 2006. Performance Improvement, the Surgical Team and Infection Control monitor surgical sites infections by type and number using evidence -based guidelines.
VIII. Accurately and completely reconcile medication across the continuum of care.	
A. Comparing current and newly ordered medications	Completed 2007
B. Communication medications to the next provider	Completed 2007
C. Providing a reconciled medication list to the patient	Completed 2007
D. Settings in which medications are minimally used	Inpatient medication reconciliation completed in 2007. In 2008, completed medication reconciliation in the outpatient departments of the hospital setting. Currently working with outpatient clinics to perform medication reconciliation.
IX. Reduce the risk of patient harm resulting from falls.	
A. Implementing a Fall Reduction Program	Completed in 2006-2007. Created a Fall Reduction Program which includes, patient risk assessment for falls on admission, monitoring for falls while in the hospital, patient and family education regarding fall prevention. Falls Team created in 2006 to review falls to decrease number of falls.
X. NA for Critical Access Hospitals	
XI. NA for Critical Access Hospitals	
XII. NA	
XIII. Encourage patients active involvement in their own care as a patient safety strategy.	Completed in 2008. DMH has established processes for reporting concerns related to care, treatment and services.

XIV. NA for Critical Access Hospitals	
XV. NA for Critical Access Hospitals	
XVI. Improve recognition and response to changes in a patient's condition.	
A. Requesting assistance for a patient with a worsening condition	Completed 2008. DMH has established an emergency response team called HELP. (Hospital Life Early Preservation). This team responds to staff's concerns about a patient's medical condition to assess and use protocols that are physician endorsed.
Universal Protocol	All 3 elements are already a part of the surgical pre-procedural process. DMH has reviewed the process in conjunction with other clinical department performing minimally invasive procedures to ascertain uniformity to the process throughout the hospital.
A. Conducting a pre-procedure verification process	
B. Marking the procedure site	
C. Performing a Time-out	