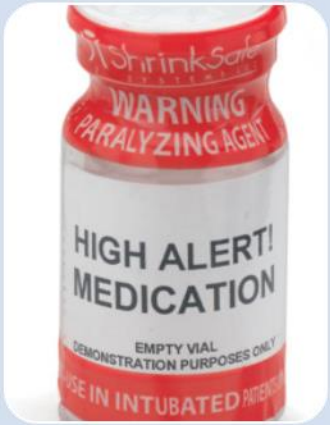
# PATIENT SAFETY GOALS





## GOAL 1

IDENTIFY PATIENTS CORRECTLY

## GOAL 2

IMPROVE EFFECTIVE COMMUNIC ATION

## GOAL 3

IMPROVE THE SAFETY OF HIGH RISK MEDICINE

## GOAL 4

ENSURE CORRECT PATIENT-CORRECT SITE-CORRECT SURGERY

## GOAL 5

REDUCE THE RISK OF HAI

## GOAL 6

REDUCE THE RISK OF PATIENT HARM FROM FALLS

# 1. IDENTIFY PATIENTS CORRECTLY

**USE AT LEAST TWO IDENTIFICATION PARAMETERS**

- **NAME OF PATIENT (FULL NAME WITH SURNAME)**
- **UHID NO**
- **DATE OF BIRTH**

- **Identify patients before any medication**
- **Identify patients before any procedure**
- **Identify patients before drawing samples or taking urine/ stool sample**
- **Identify patients before blood transfusion**

# 2. IMPROVE EFFECTIVE COMMUNICATION

- **FOLLOW THE AIDET & ISBAR METHOD OF COMMUNICATION**

- **A-ACKNOWLEDGE**
- **I-INTRODUCE**
- **D-DURATION**
- **E-EXPLAIN**
- **T-THANK**

- **I-IDENTIFY**
- **S-SITUATION**
- **B-BACKGROUND**
- **A-ASSESSMENT**
- **R-RECOMMENDATION**

- **High quality handovers are essential for safe healthcare and are used in many clinical situations.**
- **Miscommunication during handovers can lead to unnecessary diagnostic delays, patients not receiving required treatment, and medication errors.**
- **Miscommunication is one of the leading causes for adverse events resulting in death or serious injury to patients.**
- **The process of handovers can be improved by using the ISBAR Tool during handovers**

# Example of ISBAR tool in clinical setting

- **A Staff Nurse has an order for a child to have fluids by mouth as he is admitted with vomiting & abdominal pain. Initially, the patient has pain in the periumbilical area and now it is radiating to the right lower quadrant. The ordering physician needs to be called to review the patient's condition and clarify the order regarding fluid intake.**
- *Identification:* "Dr. Singh, this is Ritu from Pediatric ward"
- *Situation*: I have an order for clear fluid intake for Jai, age 8 years with abdominal pain, I would like to update you regarding Jai's condition and clarify orders with you."
- *Background*: "I see that Jonny was admitted through Emergency Department with abdominal pain (pain score 5) and vomiting. His abdominal pain has gotten worse (pain score 6) and now radiating to right lower quadrant. Oral fluids were ordered for him."
- *Assessment*: "Jonny looks unwell as his abdominal pain has increased (pain score 6) and he has been throwing up more since he was admitted (4 times)."
- *Recommendation*: "I think we should keep him nil per os (NPO) and give him intravenous fluids. Do we need to arrange ultrasound to rule out appendicitis?"

- *Identification:* This is Mrs Lakshmi Tripathi with UHID No-1234/19
- *Situation*: She is 78 year old female under Dr. So-And-So. Alert & Oriented but forgetful. No allergies, No isolation
- *Background*: She came in with pneumonia. Her past medical history includes COPD and diabetes. She came in yesterday …
- *Assessment*: **(Vital signs)** Her vital signs are stable. Afebrile. No pain.
  **(Activity)** She can get out of bed to chair with 1 assist.
  **(IVs)** She has 2 peripheral IVs in the right AC from two days ago. No drips but gets IV antibiotics.
  **(Skin)** Her skin is intact. Palpable pulses.
  **(Lungs)** She's on 2 L nasal cannula sating 95%. Lungs diminished bilaterally.
  **(GI)** Active bowel sounds. Regular diet. Last bowel movement was today.
  **(GU)** Voids. Good urine output.
  **(Glucometer)** No fingerstick.
  **(Labs)** She needs a CBC and BMP in the morning.
- **Current lab investigation** Her WBC is elevated.
- *Recommendation*: I recommend ID (infectious disease) consult on her.

CRITICAL ALERT PROTOCOL

**The Critical Alert Value Policy** outlines the process in which a critical result from the Clinical Laboratory & Radiology Department is conveyed to the consultant or other clinical healthcare provider.

A **Critical (Alert) Value:** A critical value represents a pathophysiologic state at such variance with normal as to be life-threatening unless something is done promptly and for which some corrective action can be taken; those results that may require rapid clinical intervention.

Since alert values represent potentially life threatening values, it is essential for patient care that these values be communicated in an orderly, timely and appropriate manner.

When a Critical Value is obtained the Laboratory personnel will contact the appropriate RMO & concerned consultant and report the Critical Value. Have the person **READ BACK** the value(s) for accuracy.

Once the critical value is communicated to the RMO, it is the responsibility of that person to communicate the critical value to the concerned consultant or designee.

It will be the responsibility of the RMO (who has received the Critical Alert) to document the Critical Alert duly signed, dated & timed. It shall also document the intervention advised by the concerned consultant. This note is to be verified by the concerned consultant during his visit.

VERBAL ORDER PROTOCOL

**Policy:** Verbal orders will be given only when there is some emergency situation & the doctor is busy with some procedure & acceptable only for some defined medication.

In the case of in patients, in emergency situations if the doctor gives any verbal orders or telephonic orders regarding medicines to be administered to a particular patient.

- The individual accepting the verbal order shall record and then read back the order in its entirety to the prescribing physician at the time the order is given, documenting that the order was “read back” (RB).

- Nursing staff shall tag all verbal orders with a “SIGN HERE & DATE” tag to alert the physician of the need to sign the verbal order upon return to the unit.
- Nursing staff are permitted to act upon verbal orders provided the orders contain the appropriate information.
- Verbal and telephone orders shall be signed or initialed by the prescribing practitioner as soon as possible, not later than 24 hours.
- When the ordering physician is unavailable, it is acceptable for another team member or the attending staff to authenticate the verbal order

# 3. IMPROVE THE SAFETY OF HIGH RISK MEDICATION

- LIST OF HIGH ALERT MEDICINES, CONCENTRATED ELECTROLYTES & LOOK ALIKE – SOUND ALIKE (LASA) MEDICINES
- LABELLING OF LASA MEDICINES
- STORAGE OF HIGH ALERT MEDICINES & LASA DRUGS TO BE UNIFORM ACROSS THE HOSPITAL
- IDENTIFY AREAS WHERE CONCENTRATED ELECTROLYTES ARE CLINICALL NECESSARY

# STRATEGIES TO AVOID ERRORS INVOLVING HIGH ALERT MEDICATION

## STORAGE

- All High Alert Medication containers, product packages and loose vials or ampoules stored must be labeled as **'HIGH ALERT MEDICATION'**
- All personnel should read the ***High Alert Medication*** labels carefully before storing to ensure medications are kept at the correct place
- All ***High Alert Medications*** should be kept in individual labeled containers. Whenever possible, **avoid sound-alike and look-alike drug or different strengths of the same drug being stored side by side.**

# PRESCRIBING

- Do not use **abbreviations** when prescribing
- Specify the **dose, route, and rate of infusion** prescribed (eg: IV Dopamine 5mcg/kg/min over 1 minutes)
- Prescribe oral liquid medications with the **dose specified in miligrams**
- Do not use **trailing zero** when prescribing (eg: 5.0mg can be mistaken as 50mg)

# ADMINISTRATION

- **The following particulars shall be independently counter checked against the prescription or medication chart at the bedside by two appropriate persons before administration:**
  - **Patient's name and UHID No**
  - **Name and strength of medication**
  - **Dose**
  - **Route and rate**
  - **Expiry date**

- Return all **unused medication** to pharmacy when no longer required
- Avoid **ordering** ***High Alert Medications*** **verbally**. In cases of emergency, phone orders have to be repeated and verified

# MONITORING

- Closely monitor vital signs, laboratory data, patient's response before and after administration of medication
- Keep antidotes and resuscitation equipment in wards

# TRAINING

- ❑All personal shall be trained prior to handling of High Alert Medication and documentation kept.
- ❑Staff must be trained to prevent potential errors and enable them to response promptly when mistakes do occur

## INFORMATION

- ❑ **References or dilution guide should be made available in the wards**

## EVALUATION OF ACTION

- ❑ **Monitor adverse drug reaction and medication errors related to High Alert Medications**

SAFE MEDICATION & MONITORING


SAFE MEDICATION
RIGHT TIME
RIGHT MEDICINES
RIGHT PATIENT
RIGHT ROUTE
RIGHT DOSE
RIGHT REASON
RIGHT RESPONSE
RIGHT TO REFUSE
RIGHT DOCUMENTATION
RIGHT ASSESSMENT

# Improve the safety of using medications.

- *Look Alike & Sound Alike drugs to stored separately*
- *Colour coding for Look Alike & Sound Alike drugs to be followed*
- *IV Solutions, drug concentrations, doses & administration time are standardized whenever possible*
- *Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.*
- *Maintain and communicate accurate patient medication information.*
- *Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.*

  **Labels include the following:**
  **- Medication name**
  **- Strength**
  **- Quantity**
  **- Diluent and volume (if not apparent from the container)**
  **- Expiration date when not used within 24 hours**
- **Expiration time when expiration occurs in less than 24 hours**

# Improve the safety of using medications.

- *Legible & intact labels on all drugs/ medicines/ fluids, etc.*
- *Medications will be prepared at the patient's bed side*
- *Close monitoring for any adverse drug reaction*
- *Follow the 10 Rs of Medication*
  - ✓ *Right Patient*
  - ✓ *Right Drug*
  - ✓ *Right Dose*
  - ✓ *Right Time*
  - ✓ *Right Route*
  - ✓ *Right Documentation*
  - ✓ *Right Reason*
  - ✓ *Right Response*
  - ✓ *Right Assessment*
  - ✓ *Right to Refuse*

# 4. ENSURE CORRECT SITE-CORRECT PROCEDURE-CORRECT PATIENT

**The organization develops an approach to ensuring correct-site, correct procedure, and correct-patient surgery**

**1. Ensure the correct site, correct procedure, and correct patient**

**2. Mark surgical site identification and involve the patient in the marking process**

**3. Verify that all documents and equipment needed are on hand, correct, and functional**

**4. Use time-out procedure before starting a surgical procedure**

# 5. REDUCE THE RISK OF HEALTH CARE–ASSOCIATED INFECTIONS

**1. Policies to reduce the risk of health care-associated infections**

**2. Adopt or adapt currently published and generally accepted hand hygiene guidelines**

**3. Implement an effective hand hygiene program**

# 6. REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALL

**The organization develops an approach to reduce the risk of patient harm resulting from falls.**

**1. Policies to reduce the risk of patient harm resulting from falls.**

**2. Implement initial assessment of patients for fall risk and reassessment when indicated.**

**3. Implement measures to reduce fall risk for those assessed to be at risk.**

# Sentinel Event

## What is a sentinel event?

# Sentinel Event

**A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:**

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

Such events are called "sentinel" because they signal the need for immediate investigation and response.

# SENTINEL EVENT:

- Loss of limb or function
- Patient on suicide watch commits suicide
- Unexpected death of full-term infant
- Infant/ patient abduction
- Patient runs away (elopes/ absconding)
- Infant discharged to wrong family
- Rape
- Suicide
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Surgery on wrong patient/wrong body part
- Radiation therapy to the wrong body region or 25% above the planned dose.
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm