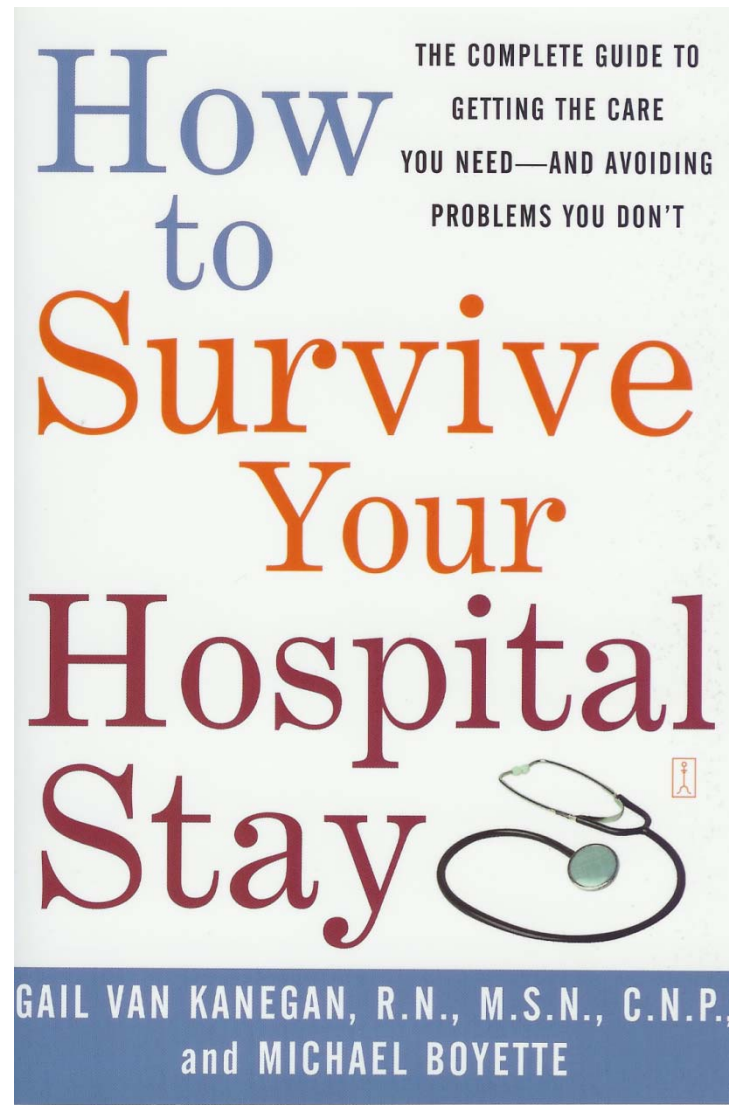


California Pacific Medical Center

Patient Safety and NPSGs

The Public's View

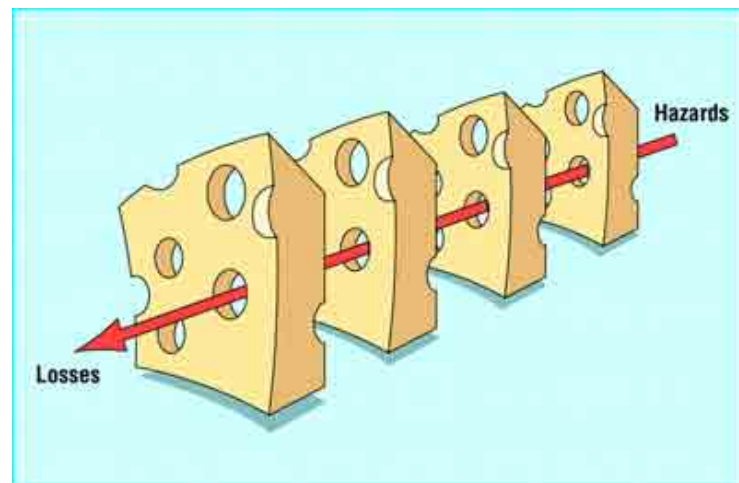
- More than 4 out of 10 American consumers report that they themselves or a member of their family has experienced a medical error
- 1 in 3 physicians report the same experience
- 1 in 4 patients admitted to a hospital experiences an adverse drug event that causes death, disability or harm



New Approach to Patient Safety

- Most errors are made by good (but fallible) people working in often dysfunctional systems

- Swiss cheese model when the holes align . . . errors occur



- We need to fix our systems to catch “the inevitable lapses of mortals”

What is CPMC doing to improve patient safety?

- We are committed to being in full compliance with the Joint Commission's "National Patient Safety Goals" (www.JCAHO.org for more information)
- We participated in the IHI 100K Lives Campaign and are enrolled in the IHI 5 Million Lives Campaign (www.IHI.org)
- Leapfrog named CPMC as one of the top 50 hospitals in the nation in 2006, 2007, and 2008

National Patient Safety Goals

- JC web site for 2010 Safety Goals:

http://www.jointcommission.org/NR/rdonlyres/E4ADEAB0-10C6-494A-9EE4-FDBC28337D65/0/HAP_2010_NPSG.pdf

- Identify patients correctly
- Improve Staff communication
- Use Medications Safely
- Prevent Infection
- Check patient medicines
- Identify patient safety risks

Improve Accuracy of Patient Identification

- At CPMC, we use **two** patient identifiers:
- NAME and **either** DATE OF BIRTH or MEDICAL RECORD
- We conduct a “Time Out” prior to invasive procedures
 - Must occur in location of procedure
 - Involves entire team
 - No barriers to speak up if you think something isn’t right
 - Verify patient, procedure, site, side (and marking if required), position, applicable implants or special equipment, signed consent

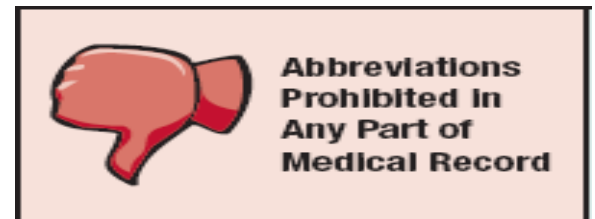


Improve Effectiveness of Communication Among Caregivers

- We take steps to assure that key verbal information is communicated clearly because communication is the most common problem underlying medical errors
- Phone or verbal orders and critical test results must be written down, read back, and confirmed
- We have established timelines (60 minutes) to assure critical test results are reported to the caregiver responsible for the patient

Improve Effectiveness of Communication

- At all campuses, we standardize the abbreviations, acronyms, and symbols that may be used including a list of abbreviations, acronyms, and symbols that are NOT permitted
- U (unit)
- IU (International Unit)
- Q.D. (daily)
- Q.O.D. (every other day)
- Trailing zero (1.0)
- Lack of leading zero (.1)
- MS
- MSO4
- MgSO4



Standardized Approach to “Hand-off Communication”

- CPMC has established standardized “hand-off communication” tools
- Key elements of the hand-off are:
 - Systems approach (with form as a guide)
 - Verbal
 - Limited interruptions
 - Up to date information
 - Ability to ask questions/verify information



This is the tool to use when a patient is transported to another area of the hospital and is not accompanied by a nurse

Date: _____

Handoff Communication:

Name: _____ Unit: _____

Glasses Dentures Hearing Aids

Code Status: _____

NPO: _____

Precautions: Fall _____ Aspiration _____
Seizure _____ Respiratory _____
Sternal _____

Pregnant: _____

Communication: Hard of hearing _____
Confused _____
Non Verbal _____ Blind _____
Language: _____

Mobility: _____

Restraints: _____

Oxygen: _____

Nurse: _____

Ext: _____

Improve Safety of Using Medication

- At CPMC, we have taken the following steps to improve medication safety:
 - Removed concentrated electrolytes
 - Standardized drug concentrations
 - Identified look-alike, sound-alike drugs
 - Label all drugs used on/off sterile field
 - Reconcile medications



Reduce the Risk of Healthcare Associated Infections

- We follow CDC hand hygiene guidelines
 - Soap & water for **15** seconds
 - or waterless alcohol-based hand gel (rub on entire hand surfaces until dry)
 - If hands are visibly soiled, soap and water is required for hand hygiene
- CDC guidelines and CPMC policy prohibits long natural nails or artificial nails for:
 - Direct patient caregivers
 - Staff who prepare pharmaceuticals, food or sterile supplies
- Hand hygiene must always occur after glove removal

Accurately and Completely Reconcile Medications

- At CPMC, we continue to improve our process for obtaining and documenting a complete list of current medications on the “Medication List” upon admission
- The list is reviewed and reconciled when the patient transfers to another level of care
- A copy of the list is given to the patient upon discharge

Falls Precautions

- CPMC assures that patients are assessed for the risk of falling on admission, every shift and more often if indicated
- ALL patients are placed on standardized falls precautions
 - Round on patient hourly for pain, toileting and personal needs
 - Orient to room, call light, bed controls, ambulation devices
 - Bed in low position
 - Clear room of clutter, spills, physical hazards
 - Place personal items within reach
 - Educate patient and family
 - Provide non-skid slippers for all ambulatory patients



Mandatory Interventions for Patients with a Falls Risk Score of 5 or Higher

- Staff must remain with patient during transferring and toileting
- Staff must remain with patient during ambulation if patient has unsteady gait
- Locate patient near nurses station if possible
- Initiate bed alarm for patients with impaired judgment
- Enter falls precautions in PCIS (except SL campus) and list interventions
- Label patient door and white board with yellow “Know the Score” sign
- Include falls risk score in all hand-off communication



If a Patient Falls....

- Refer to Appendix B in the Falls Prevention & Fall Management Protocol (PC-F-6.01A)
- Assess patient
- Head CT and Neuro Checks if indicated
- Communicate to physician and nurse manager or nursing supervisor
- Document on Fall Report Form
- Enter date of fall into “significant events” in PCIS (except SL campus)



Encourage Patients' Active Involvement in Care

- Patients are given an information sheet on Patient Safety that instructs them to “Speak Up” if they have a question or concern about patient safety
- Issues should ideally be resolved at the unit level using the chain of command but unresolved issues should be referred to the Customer Service Department



Identify Safety Risks Inherent in Patient Population

- We carefully identify patients at risk for suicide to assure their immediate safety needs and treatment are addressed



Patient Safety Doesn't Just Happen...



- You are responsible for:
 - Being careful
 - Doing it right
 - Reporting all errors and “near misses”
 - Complete appropriate occurrence report
 - For falls, use the “Falls Occurrence Report”
 - For medication errors/”near misses” use “Medication Error Report”
 - For any other event not considered with routine care, treatment or a deviation from expected patient outcome, use the “Occurrence Report”

EYES WIDE OPEN

The behavior of constantly observing both the environment and the people interacting with it for safe practices.



Key points:

- Pay attention to detail
- Include all multi-disciplinary team members and patients
- Be proactive: anticipate potential risks
- Promote teamwork and group understanding

ALWAYS IN THE MOMENT

The practice of focusing on the task or person at hand and avoiding distractions.



Key points:

- Be alert during high-risk moments (e.g., obtaining and administering medications, performing a procedure on a patient, entering information into a computer database, working around sensitive equipment, etc.)

TALK TO ME

The practice of comprehensive vertical and horizontal communication of vital information.



Key points:

- Ask clarifying questions: communication is interactive
- Include key components: specific to area and activity
- Focus on priority "need-to-know" information
- Make it a habit: use a standard approach every time

NEVER LEAVE YOUR WINGMAN

The behavior of mutual support among team members that creates a safe environment to identify and correct safety risks.



Key points:

- Both observers and operators benefit
- Mutual support implies "You are not alone - I've got your back!"