2017 National Patient Safety Goals

Goal #1: Patient Identification

01.01.01: Use at least two patient identifiers when providing care, treatment or services.

- The two patient identifiers used in all areas of the hospital are **NAME & DATE OF BIRTH**. Medical record number may be used as an alternate.
- Active patient involvement should be a part of this process whenever possible.
- In Outpatient areas, Clinics and the Women's Health Center, a photo ID may be used. Permission to copy picture identification cards is obtained and copies are attached to the medical record.
- Containers for blood/other specimens are labeled in the presence of the patient.

01.03.01: Eliminate transfusion errors related to patient misidentification.

- Patient identification is performed in the presence of the patient by two RNs or RN and MD immediately prior to the administration of blood.
- Assures that the right patient gets the right unit of blood.
- If a patient is not wearing an ID band, the RN will positively ID the patient with the help of other care givers and the Medical Record AND will place a hospital ID band (with name, date of birth and MR#) on the patient.
- All information on the Blood Bank Transfusion Slip must be verified and documented by two qualified individuals (two RNs or RN and MD).
- If any discrepancies exist, the transfusion cannot be started until they are resolved by the Blood Bank and the information is verified as acceptable to transfuse per doctor's order.

Goal #2: Effective Communication Among Caregivers

02.03.01: **Report critical results of tests and diagnostic procedures on a timely basis.**

- **Documentation Requirements:**
  - All Critical Results from Laboratory, Respiratory and Diagnostic Areas
  - Requires the completion of a *Critical Test Results Form* by the RN
  - The *Critical Result Test Results Form* is found in SCM:
    Print Forms ⇨ Forms ⇨ Critical Test Form
  - Once completed the *Critical Test Results Form* is placed in the medical record in the "Physician Record" section of the chart.

- **Documentation Reminders:**
  - All elements on the Critical *Test Results form* must be completed by the RN.
  - Special attention when documenting on the *Critical Test Result form* to:
    - Readback by MD
    - Action on the result: ⇨ New Orders or No Orders

- **Time Frames:**
  - Time of result known by the resulting department to contact with nursing unit RN:
    - 15 minutes
  - Time RN receives result to contact the MD
    - 15 minutes
  - Time MD contacted by RN to time MD contacts RN with action plan:
    - 30 minutes

Goal #3: Medication Safety

03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in peri-operative and other procedural settings.

- All medications and medication containers (such as syringes, medicine cups, basins and other solutions), both on and off the sterile field, must be labeled.
- Labels must include medication/solution name, strength, dosage, expiration date, and initials.
- Any medication/solution that is going to be used immediately requires name and dosage only.
- All labeling should be verified both verbally and visually by two qualified individuals when the person preparing the medication/solution is not the person who will administer the solution. Verification must be completed where the medication is prepared.

Medication Safety

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

- Anticoagulation therapy is individualized using approved protocols and procedures.
  - **IV Heparin**: follow the **weight based protocol**; only premixed standard concentrations are used. Heparin infusions are only administered with a programmable infusion pump.
  - **Subcutaneous Heparin**: monitor coagulation labwork. Heparin is stored in the Pyxis in single use vials in single access pockets; available concentrations are limited.
  - **Warfarin therapy**: unit-dose Warfarin is stored in the Pyxis in unit dose wrappers in single access pockets. Patients will fall into one of two categories:
    - **New start of therapy or a current patient with fluctuation**
    - **Stable Warfarin maintenance patients**

Warfarin:

- Order with identification of a target INR, either in SCM or on the Warfarin order form.
- A current INR must be present prior to administration of Warfarin.
- INR value confirmation is entered into PYXIS at medication removal.
- Warfarin tablets are **ONLY** to be split by pharmacy staff.

Education and Monitoring

- Monitor patient for signs of bruising, bleeding, or decrease in hemoglobin.
- Document patient education regarding:
  - Compliance issues
  - Dietary advice
  - Follow-up monitoring
  - Potential for adverse drug reactions (like bruising or bleeding) and interactions

Medication Safety

03.06.01 Maintain and communicate accurate patient medication information.

- Obtain and document a complete list of the patient's current meds upon admission and obtain admitting orders from the Physician if none are present on the chart.
- Compare the meds ordered by the Physician with those on the patient's current med list from home or other facility. Review meds with attending physician to ensure meds are continued or discontinued, as appropriate.
- Medication reconciliation is completed and updated in the Clinical Information System.
- If the patient is scheduled for the OR, the surgeon must review and reconcile all pre-op and post-op medication orders.
- When transferred to another unit or facility, the current medication list must be communicated to the next provider of care.
- When the patient is discharged, communicate the current med list to the patient or caregiver. Provide complete instructions about which meds to resume, discontinue or start at home.

Medication Safety

- ***Unlicensed staff may work in areas where medication is stored.***
  - *Unlicensed staff may check for expiration dates of kits with medications.*
  - *Unlicensed staff may transport trays with medications to the nurse or physician.*
- ***Unlicensed staff may not open, tamper, or administer any medication.***

Goal #6: Clinical Alarm Safety

06.01.01 Improve the safety of clinical alarm systems.

- Clinical alarms systems are intended to alert caregivers of potential patient problems, but if they are not properly managed they can compromise patient safety.
- Definitions:
  - Alarm: an audible or visual signal intended to get someone's attention
  - Alarm fatigue: the sensory overload when clinicians are exposed to an excessive number of alarms which can result in desensitization to alarms and missed alarms.
  - Alarm priority levels: provides guidance about how to respond to a clinical alarm.
- Prioritization of alarms is based on:
  - Input from medical staff and clinical departments
  - Risk to patients if the alarm signal is not attended to or if it malfunction
  - Potential for patient harm based on internal incident history
- Clinical Staff must:
  - Respond promptly to visual and/or audible clinical alarms to correct the cause.
  - Maintain the alarms in the "on" position, configured in accordance with the parameters set and sufficiently audible to staff as long as the equipment is being used for the patient.
  - Alarms may be suspended while he patient is disconnected from the equipment, but must be turned back to the "on" position when the equipment is placed back on the patient.

Alarm Priority Levels

ADDENDUM A

Management of Clinical Alarms – Alarm Priority Level

Alarm priority level – Provides guidance about how to respond to a clinical alarm. There are three levels of alarm signals that are managed: Level C, Level B, and Level A.

Level A (Red) **Immediately life threatening, high priority**	Level B (Yellow) **Potentially life threatening, medium priority**	Level C (Blue) **Inattention for a short period is not likely to result in patient harm, low priority**
Response: requires immediate attention. Inattention to this alarm may result in a devastating clinical event	Response: requires attention as quickly as possible but is not considered an emergency. Level B alarms should be addressed in a timely manner.	Response: advisory alarm signals are meant to call the clinicians attention to a medical device or patient condition that needs re-assessment.

See Policy for list of clinical alarms and their priority level designation.

Goal #7: Reduce the Risk of Health Care Associated Infections

07.01.01: Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

- Scrub hands for 20 seconds before eating, after using the restroom and whenever hands are visibly soiled.
- Alcohol based hand rub can be used instead of hand washing in all other clinical situations.
- Wear gloves appropriately.
- Maintain fingernail length to ¼ inch or less; no artificial nails.
- ALL employees must wash their hands or use a hand sanitizer when entering AND leaving a patient's room.

07.03.01: Implement evidence-based practices to prevent health care associated infections due to multiple drug-resistant organisms (MDROs) in acute care hospitals.

Three examples of MDROs are MRSA, VRE and CRE.

Trinitas practices include:

- Staff/Patient/Family education about infection prevention strategies.
- Hand hygiene
- Contact precautions (use of gloves and gown for all room entry)
- Cleaning and disinfecting all shared equipment

Reduce the Risk of Health Care Associated Infections

07.04.01: Implement evidence-based practices to prevent central line associated bloodstream infections.

- Use catheter insertion checklist and catheter kit
- TEAM APPROACH: Nurse and Doctor at bedside together during insertion
- Staff Education/patient/family education about central-line infection prevention
- Hand hygiene before insertion
- Aseptic technique
- Proper attire during insertion: hair covering, mask, gown, and gloves
- Avoid femoral lines
- Maintenance includes: antiseptic before access, keeping dressing clean and dry; use of biopatch (chlorhexidine patch)
- Use of caps to protect ports
- Removal of nonessential central lines

07.05.01: Implement evidence-based practices for preventing surgical site infections.

- Education of staff, patients and their families regarding surgical site infection prevention.
- Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to SCIP guidelines.
- Use clippers when hair removal is necessary.

Reduce the Risk of Health Care Associated Infections

07.06.01: Implement evidence-based practices to prevent catheter-associated urinary tract infections. CAUTI (Catheter-associated urinary tract infections)

Indications for indwelling catheter

- Urinary retention/obstruction
- Surgery: pre-op and post-op monitoring
- Hemodynamically unstable patients
- Wounds (stage 3 or 4), severe incontinence dermatitis
- Upon request for comfort in end of life care

CAUTI Collaborative Bladder Bundle

- **A**septic insertion and proper management
- **B**ladder ultrasound may help to avoid indwelling catheterization
- **C**ondom catheters or intermittent catheterization in appropriate patients
- **D**O NOT use indwelling catheter unless you must
- **E**arly removal of catheters

- **Indwelling** foley catheters have time limits **and must be reordered every 48 hours** and are evaluated daily for need by nursing staff.

Goal #15: Identify Safety Risks Inherent in Our Patient Population

15.01.01: Identify patients at risk for suicide.

- Warning signs include, but are not limited to: acting depressed or withdrawn, sleeping too much or too little, talking about suicide, death or ending it all, refusing food, fluid or medications, etc.
  - All ED patients should be screened for suicide risk.
- Protecting patients at risk:
  - Relocate patient to a room near the nurse's station.
  - 1:1 supervision until evaluated by a psychiatrist.
  - Post sign outside of door instructing visitors to STOP – Report to the Nurse's Station before entering.
- Secure a safe environment:
  - Remove all potentially dangerous objects from the room, including but not limited to matches, lighters, razors, shoelaces, phone cords, call bell cords, light cords, cleaning agents, plastic bags/garbage bags, etc.
  - ALERT nursing staff on unit, housekeeping, dietary to avoid leaving potentially harmful items in room.
- **What You Can Do – The most important actions to prevent suicide are:**
  - Recognize early warning signs; Listen carefully to your patients. Notify the nurse on the unit whenever a patient talks about suicide.
  - Provide prompt medical and psychiatric treatment.
  - Do not be afraid to ask the patient if he or she has thoughts about their own life –
    - YOU WON'T BE PUTTING IDEAS IN HIS/HER HEAD!

Universal Protocol

- **UP.01.01.01: Conduct a pre-procedure verification process**
  - Identification/verification of the correct patient, procedure, site and side (as appropriate) is completed at the following times:
    - When the surgery/procedure is scheduled
    - When the patient is admitted to the facility
    - When the patient is transferred from one caregiver to another.
- **UP.01.02.01: Mark the procedure site**
  - **AFTER identifying** the correct patient, procedure and location on the body AND **BEFORE entering** the operating or procedure room, the side/site of the procedure is marked by the **surgeon's/proceduralist's with his/her initials** at or near the incision site.
- **UP.01.03.01: An ACTIVE time-out is performed immediately prior to starting procedures.**
  - The time out is performed to correctly identify the correct patient, the correct procedure and the correct site/side.
  - The **final verification** or **"time-out"** is done immediately prior to the start of the procedure. **ALL** team members must remain present in the room after the final verification has been done or it will have to be repeated.