

2012 National Patient Safety Goals

Patient Identification

- Use 2 patient identifiers (**Name & DOB**) when **administering medications, blood or blood components; when collecting blood samples and other specimens and when providing treatments or procedures.**
- Label containers used for blood and other specimens **in the presence of the patient.**
- Before initiating bld or bld products, match bld to the order and match patient to the bld.



Communication

- Write down verbal order given, then "Read Back" the complete order or critical test result. For verbal orders/telephone orders- use hot pink sticker & check box "read back and verified".
- Critical lab results- **DOCUMENT** time lab was resulted, time nurse called and time provider notified and action taken.
- Be familiar with the "DO NOT USE" Abbreviations
- Use LJCMC standardized process for hand-off communications "**SBAR**"- refer to name badge reminder



Medication Safety

- Label all medications, med containers, or other solutions that are not immediately administered. Draw up medication in syringe and label if not immediately administered----label with **name of med, strength, and amount**
- Reduce harm with anticoagulant therapy. Document INR prior to adm. Coumadin. Call MD if INR > 4. Follow pre-printed order form.
- Provide education regarding anticoagulant therapy to patients and families.



Medication Reconciliation

- Complete list of medications on entry to facility, inclusive of dose, route and frequency- Document list in CLIQ
- Home Medications reconciled with those given during visit. Discrepancies documented in CLIQ.
- Transfer reconciliation required; handoff communication needed- documented on transfer form.
- Medications reconciled in CLIQ @ discharge. Pt. given a copy of home med. list and copy placed in medical record. If pt. is transferred, copy sent to transferring facility.

Universal Protocol

- Procedure verification- Verify Name and DOB, correct procedure, correct site; relevant documentation (H&P, consent) and labeled diag/radiology results and any equip/devices and/or blood products.
- Site marking for procedures involving incision or percutaneous puncture, done by LIP accountable for procedure and will be present when procedure is performed. Site marking done prior to moving to OR suite & with pt's involvement.
- **Time-outs include an active communication with whole team verifying correct patient, correct site, and correct procedure. Time-outs must be documented on Universal Protocol form.**

Identify Safety Risks

- Patients assessed for "suicidal triggers" upon admit and throughout their stay- document low or high risk. MD notified if high risk and special observation procedures are implemented.
- If pt. is suicidal, a Suicide Lethality Screen Nursing Assessment is completed in consultation with physician and appropriate observation implemented. Document patient observations on Nursing Obs. Log.



Reduce the risk of Health Care-Associated Infections

- 1) **Comply with hand washing guidelines.**
 - Use Avagard hand gel **BEFORE & AFTER** patient contact; unless hands visibly soiled - then use soap and water.
 - Perform handhygiene for 20 seconds.
- 2) **Practices to prevent HAI due to MultiDrug Resistant Organisms (MDROs)** –MRSA, VRE, CDIFF, etc.
 - MDRO alerts from lab when organism identified
 - MDRO Database on "U" Drive
 - MDRO alert to printer for patients readmitted w/MDROs
 - Educate pt/family MDRO prevention (education sheet)
 - Document education on interdisciplinary education record
 - **NO HAND GEL for C-Diff patients** -use soap & water
 - Isolation precautions & standard precautions
 - MDRO alert bracelet (Lime green)
- 3) **Practices to prevent Central associated blood stream infections (CLABSIs)**
 - Educate pt/family about CLABSI prevention – **document**
 - Use central line insertion safety checklist
 - Use standardized kit or kit plus maximum barrier tray
 - Use maximum barrier precautions (mask/gown/gloves/drape)
 - Use of chlorohexidine antiseptic/CHG dressing
 - Femoral vein avoidance for access
 - Scrub hubs & injection ports before accessing.
- 4) **Practices to prevent surgical site infections (SSI)**
 - Patient education on SSI prevention –document on patient interdisciplinary education record/preop record
 - Sage (CHG) baths night before and morning of surgery
 - **No razors- clippers only if hair removal needed**
 - Prophylactic antibiotic within 1 hr prior to incision

Reduce the Risk of Harm From Falls

- Risk assessment completed on entry to facility
- Reassess fall risk daily
- **Yellow Stars** outside door and yellow fall sticker placed on armband, front cover and spine of chart.
- Patient and family educated on fall reduction program and individual ways to prevent falls.
- Utilize bed alarms as necessary



Fall Risk

YOU HOLD the KEY to PATIENT SAFETY!!

