

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6001
DEPARTMENT: HOSPITALWIDE	PAGE: 1 OF: 1
APPROVED BY:	EFFECTIVE: REVISED:

PURPOSE:

- The purpose of the organizational Patient Safety Plan at _____ Hospital is to improve patient safety and reduce risk to patients through an environment that encourages:
 - Integration of safety priorities into all relevant organization processes, functions and services
 - Recognition and acknowledgment of risks to patient safety and medical/health care errors
 - The initiation of actions to reduce these risks
 - The internal reporting of what has been found and the actions taken
 - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
 - Minimization of individual blame or retribution for involvement in a medical/health care error
 - Organizational learning about medical/health care errors
 - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at _____ Hospital. The Patient Safety Plan, developed by the interdisciplinary Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

COMPONENTS OF A PATIENT SAFETY PROGRAM

PATIENT SAFETY PROGRAM CHECKLIST

Your patient safety program should include:

- Designated individual or individuals** (such as a team) to coordinate and oversee the patient safety program
- Program components include:**
 - Definition of the scope of the program activities** (occurrences to be addressed) such as “no harm” occurrences through sentinel events with serious outcomes and inclusion of the National Patient Safety Goals
 - Declaration that focus of program is on improving patient safety processes, not punitive measures against staff that commit errors**
 - Description of the mechanisms to ensure that all components your organization are integrated into and participate in the organization-wide program** (that is a description of how your organization is sure all appropriate departments and services within your organization are included in the program and how your organization is sure there is participation in the program from these departments and services)
 - Procedures for immediate response to medical/health care errors** (that is, how clinical *and* administrative staff will immediately respond to a medical/health care error). Response procedures are in place for:
 - Care of the affected patient(s)
 - Containment of risk to others
 - Preservation of factual information for subsequent analysis
 - Definition of the systems in place for internal and external reporting** of information relating to medical/health care errors
 - Definition of mechanisms in place for responding to various types of occurrences** such as: root cause analysis in response to a sentinel event or mechanism for conducting proactive risk reduction activities
 - Defined mechanism** (policy and procedure) **for support of staff** who have been involved in a sentinel event

SUBJECT: DECREASING MEDICATION ERRORS	REFERENCE #3001
DEPARTMENT: HOSPITALWIDE - PATIENT CARE	PAGE: 1 OF: 1
APPROVED BY:	EFFECTIVE: REVISED:

POLICY:

- It is the policy of _____ Hospital to institute a “Medication Safety Awareness” program and to take a proactive approach by focusing performance improvement activities on medication use. Be aware that errors can occur at any step of the process: prescribing, ordering, dispensing, administering or monitoring the effects of the medication.
 - The Institute for Safe Medication Practices has identified some common sources of errors:
 - Unavailable patient information prior to dispensing or administering a drug (lab values, allergies, etc.)
 - Unavailable drug information (written resources)
 - Miscommunication of drug orders (similar names, use of zeros, inappropriate abbreviations, poor handwriting)
 - Problems with labeling, packaging
 - Drug standardization, storage (stocking multiple concentrations of the same drug, look-a-like containers)
 - Drug device use and monitoring (lack of standardization in drug delivery devices, unsafe equipment)
 - Environmental stress (distractions, noise during transcription or dispensing, too long shifts)
 - Limited staff education (on problem-prone drugs)
 - Limited patient education
 - The Institute for Safe Medication Practices also determined that a majority of medication errors resulting in death or serious injury were caused by “high alert medications”:
 - Insulin
 - Opiates and narcotics

MEDICATION ERROR ANALYSIS TOOL

Date/Time of Error: _____ Med Record #: _____ Drug/Name: _____

Doses Involved: _____ Patient Name: _____

Summary of Occurrence: _____

The Medication Error Classification System: (Please circle the level that applies to this error.)

Level 0: No error occurred, potential error.	Level 1: Error occurred without harm to patient.
Level 2: Error occurred, increased monitoring but no change in vital signs or any patient harm.	Level 3: Error resulted in need for increased monitoring, there was change in vital signs but no ultimate patient harm; any error needing increases laboratory monitoring.
Level 4: Error resulted in need for treatment with another drug, increased length of stay, patient transfer to a higher level of care (i.e., ICU), or required intervention to prevent permanent impairment of damage.	Level 5: Error resulted in permanent patient harm.
	Level 6: Error resulted in patient death.

Error Type: (check all that apply)

- | | | | | |
|--|--------------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> wrong drug | <input type="checkbox"/> or solution | <input type="checkbox"/> unordered drug | <input type="checkbox"/> wrong dose | <input type="checkbox"/> or rate |
| <input type="checkbox"/> omission | | <input type="checkbox"/> wrong dosage form | <input type="checkbox"/> expired drug | |
| <input type="checkbox"/> wrong route | | <input type="checkbox"/> wrong patient | <input type="checkbox"/> incompatible infusions administered | |
| <input type="checkbox"/> wrong administration time | | <input type="checkbox"/> prescribing error | <input type="checkbox"/> other _____ | |

Factors Contributing to Error: (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> verbal order | <input type="checkbox"/> illegible order | <input type="checkbox"/> continued after order to discontinue |
| <input type="checkbox"/> monitoring guidelines not followed | <input type="checkbox"/> midnight check done incorrectly | <input type="checkbox"/> medication delivery delay |
| <input type="checkbox"/> telephone order | <input type="checkbox"/> routine medications not in cassette | <input type="checkbox"/> ambiguous written order |
| <input type="checkbox"/> MAR printed incorrectly | <input type="checkbox"/> dispensed incorrectly by Pharmacy | <input type="checkbox"/> drug selected from floor stock |
| <input type="checkbox"/> pump malfunction (specify pump type) _____ | <input type="checkbox"/> pump misprogrammed (specify pump type) _____ | |
| <input type="checkbox"/> RN verified incorrect transcription | <input type="checkbox"/> drug or solution mislabeled by Pharmacy | <input type="checkbox"/> misread MAR |
| <input type="checkbox"/> new bag not reordered until present bag very low or empty | <input type="checkbox"/> medications unavailable from Pharmacy | <input type="checkbox"/> IVPB hung ahead of time |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | |

Personnel involved: (check all that apply)

- | | | | |
|---------------------------------------|-----------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> RN | <input type="checkbox"/> LPN/LVN | <input type="checkbox"/> LPT | <input type="checkbox"/> US/NT |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Per Diem | <input type="checkbox"/> Registry | <input type="checkbox"/> MD |
| <input type="checkbox"/> Other: _____ | | | |

Problem Resolution/Outcome (use back of form if more room needed):

Signature: _____ Date: _____

SUBJECT: INVASIVE PROCEDURE SITE IDENTIFICATION	REFERENCE #2015
DEPARTMENT: SURGICAL SERVICES	PAGE: 1
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APPROVED BY:	EFFECTIVE:
	REVISED:

POLICY:

To identify unambiguously the intended site of incision or insertion, the invasive procedure and site/side will be verified by the patient and/or family, the licensed healthcare professional assigned as the patient's care provider (nurse, imaging services tech, etc.), the licensed independent practitioner (MD, DPM, CRNA, etc.) and the anesthesia provider (if anesthesia or sedation provided during procedure) prior to initiation of the procedure. A double check verification process will be performed to assure correct procedure, patient, insertion/incision side/site prior to all invasive procedures such as bedside debridements, breast needle biopsies performed in Imaging Services, podiatric procedures performed in ambulatory settings and other areas of the institution. Additionally, all relevant documents and studies will be available prior to the start of invasive procedures. These documents and studies must have been reviewed and found to be consistent with each other and with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable, any implants prior to initiation of the procedure. Missing information or discrepancies will be addressed and resolved before starting the procedure.

PROCEDURE:

- The invasive procedure and site/side will be verified by the following means:
 - Verbal identification by the patient and/or family
 - Operative and/or other invasive procedure informed consent
 - History and Physical
 - Physician's orders
 - Department specific invasive procedure assessment checklist
- The above documents along with patient/family identification must indicate the same type and site/side of invasive procedure.
- The patient care provider will identify the patient and verify the invasive procedure and site/side in the department where the procedure is to be performed.
- The patient care provider will ensure completion of the preprocedure assessment and that all preprocedure requirements are on the patient's chart. Including laboratory results, EKG, imaging studies and other documents as appropriate to the patient's condition and the invasive procedure to be performed.
- Verification of Site/Side: