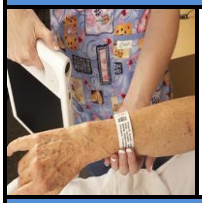
2016 National Patient Safety Goals

El Camino Hospital® THE HOSPITAL OF SILICON VALLEY

CLINICAL ALARM SAFETY

Clinical Alarms are intended to alert caregivers of potential patient problems. If not properly managed, patient safety may be compromised. To prevent excess alarm noise and potential alarm fatigue (ignoring alarms), set alarm parameters carefully. Follow unit guidelines for setting, monitoring and removing alarms. Be aware of the need to change telemetry electrodes and batteries to optimize function and decrease alarms. **Turning alarms off is never the best option for managing alarm noise.**

PATIENT IDENTIFICATION



Patient Identification—Upon greeting each patient, confirm "Right Patient" identification by checking **2 patient identifiers**. If the hospital registration armband is absent, ask the patient for name and date of birth. If the patient has an armband, verify the name and medical record number. Anytime anything is done **to** a patient, **with** a patient or **for** a patient, validation of patient identity must be done. Label all specimens with correct patient name, date, time, initials and source, at the bedside, in the presence of the patient. Verify blood or blood products with another RN (one is transfusionist) while matching product with physician order, always use medication bar-coding for patient identification where applicable.

SAFE USE OF MEDICATIONS

Labeling medications--All medications or solutions that are not immediately administered are labeled. Any medication or solution transferred from its original packaging to another container (syringe, medicine cup, basin) must include the name of medication/solution, the strength or concentration, and the volume if not apparent. Medications or solutions without a label must be discarded. Syringes cannot be pre-labeled before draw.

Reduce the likelihood of patient harm associated with the use of anticoagulation therapy: Prior to starting or adjusting warfarin therapy, evaluate a current INR. Ensure patients receiving anticoagulation therapy have individualized treatment plans. Provide education to patients and families on compliance, follow-up monitoring, dietary restrictions, and potential for adverse drug reactions and interactions. Use only pre-mixed infusions (heparin) and oral unit dose products (warfarin).

EFFECTIVE COMMUNICATION

All critical results, verbal orders, and telephone orders are written down and ***read back*** to the individual giving the order or test result. **"Repeat back"** is not the same as read back. Document ***read back*** in the Electronic Health Record (EHR).

Critical results are those abnormal values that require immediate action by the physician. The MD must be notified of critical results within 30 minutes of receiving the result. The result and time reported to the physician must be documented in the EHR along with the action taken to treat the result. An existing order or protocol must be in place to treat the result if the physician is not notified. Documentation intervention or reason for not calling physician.

MEDICATION RECONCILIATION

Upon admission, a complete list of patient medications is recorded – including over-the-counter and herbal. Medications ordered in the hospital are compared to this outpatient list by the physician at regular intervals. Written medication information is provided to the patient and family at discharge, along with emphasis on the importance of managing medications and proper administration. The patient and family are advised to carry medication information at all times in the event of an emergency situation and to provide this list every time they visit a doctor.

REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS

Hand Hygiene is the best way to prevent HAIs (Hospital Acquired Infections). Use antimicrobial gel, and rub for 20-30 seconds before entering and when leaving a patient room. Gel whenever in contact with items in a patient room, prior to and after a procedure, and when removing gloves. **USE ONLY SOAP AND WATER (scrub 40 – 60 seconds) for C. Diff.**

Prevent central-line-associated bloodstream infection by assessing the necessity of the line daily. Using best practice infection prevention measures when inserting central line.

Prevent indwelling catheter-associated urinary tract infections by assessing the need for the catheter each day; remove when use no longer justified. Maintain sterility of the urine collection system.

Prevention of surgical site infection by following prophylactic antibiotic protocols and providing patient education on prevention and document that education

Prevent Multi-drug resistant organisms (MDROs) Identify and place patient in isolation as per policy and educate patient/visitors on isolation procedures. Document education in the EHR.

UNIVERSAL PROTOCOL

Universal Protocol is the 3 step process to prevent wrong patient, wrong procedure, and wrong site procedure errors. **Pre-operative/pre-procedure verification** is required for invasive procedures requiring sedation or anesthesia. A complete Boarding Pass verifies the RIGHT patient and PROCEDURE, informed consent, H&P, site marking, and the person performing the procedure. The **Time Out (final verification)** is performed immediately before starting the operation/procedure and verifies: • Correct patient • Correct procedure • Correct site. Consents for blood administration may be included

SUICIDE ASSESSMENT

Assess and identify patients' risk for suicide. If patient exhibits suicidal behavior or intent: Stay with the patient at all times and notify the attending physician immediately. Provide Crisis Hotline to patient and family. (1-800-273-TALK)