Welcome to the lesson on Quality Outcomes, Patient Safety Goals and Event Reporting. In this lesson, we will be describing:

- The Plan-Do-Check-Adjust (PDCA) quality improvement model
- The Joint Commission’s 2013 National Patient Safety Goals (NPSG)
- Safety Event Reporting
1. **Plan**
   - Identify the goal of the improvement
   - Develop a plan (who, what, where, when)

2. **Do**
   - Carry out the plan
   - Document problems and unexpected observations
   - Begin analysis of the data

3. **Check**
   - Complete the analysis of the data
   - Compare the data to goal
   - Summarize what was learned

4. **Adjust**
   - What changes are to be made?
   - What will be the next cycle?
   - Go back to Plan, and continue the cycle to improve the intervention

When a problem is identified that requires an improvement, LPCH applies the PDCA continuous improvement cycle to guide the work.
The Joint Commission’s National Patient Safety Goals (NPSG) provide hospitals with specific areas of focus as a result of problems identified that pose risk to healthcare safety.

In 2013 there are 6 key areas of focus for the NPSG:

- Identify Patients Correctly
- Improve Staff Communication
- Use Medicines Safely
- Prevent Infection
- Identify Patient Safety Risks
- Prevent Mistakes in Surgery
Patient Identification

• Use at least two patient identifiers when providing care, treatment and services (medications, breast milk and blood products, procedures, etc.)

• Label containers used for blood and other specimens in the presence of the patient.

• Make sure that the correct patient gets the correct blood when they get a blood transfusion. Use a 2 person verification process to include:
  - Matching the blood or blood component to the order
  - Matching the blood or blood component to the patient, using the 2 patient identifiers

For inpatients, compare name and MRN with the identification band on the patient

For outpatients, compare name and date of birth
Get important test results to the right staff person on time

Critical values:

- Verify the complete order or test result by having the person receiving the information write down and "read-back" the complete order or test result.

- Communicate critical values to the responsible licensed caregiver within **one hour** of availability.

*For example:* The lab would report a critical result to a nurse on a unit within 15 minutes after the results are available. The nurse would communicate the results to the licensed independent practitioner within 45 minutes and document that the provider was notified.
Use Medications Safely

• Label all medications that are unlabeled, including those in procedural areas and on the sterile field

Labels must include:

Name of Medication
Strength
Quantity
Diluent and Volume
Expiration date/time*

*Expiration date when not used within 24 hours and expiration time when expiration occurs ≤24 hours

• Take extra care with patients who take medicines to thin their blood

• Maintain and communicate accurate patient medication information (Medication Reconciliation)
Healthcare-Associated Infections

• Use hand cleaning guidelines and set goals to improve hand hygiene
  — Gel IN, Gel OUT with alcohol-based handrub for at least 15 seconds
  — Wash with soap and water for at least 15 seconds if hands are visibly soiled
  — Do not use alcohol-based handrub for patients with c-difficile; wash with soap and water only

• Use proven guidelines to prevent infections
  — Of the blood from central lines (CLABSI)
  — From surgery (SSI)
  — Of the urinary tract that are caused by catheters (CAUTI)
  — That are difficult to treat (MDRO & C-difficile)
Suicide Risk Reduction

- Find out which patients are most likely to commit suicide

  - If a patient has suicidal behavior or intent, a psychiatric consult is required

  - Any inpatient who is identified as a risk for suicide or attempts suicide will be placed on suicide precautions with constant 1:1 monitoring

  - When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as crisis hotline 1-800-273-TALK) to the patient and his or her family

*Suicide risk assessment applies only to patients being treated for emotional or behavioral disorders.*
Universal Protocol

- Make sure the correct surgery is done on the correct patient and at the correct place on the patient’s body
- Mark the correct place on the patient’s body where the surgery is to be done
- Pause before the surgery to make sure that a mistake is not being made (Time Out)
- Active participation in the process by all members of the team is required

The goal of Universal Protocol is to prevent:
- wrong site
- wrong patient
- wrong procedure or surgery

It is used for all surgical and nonsurgical invasive procedures
Reporting Safety Events

- At Packard Children’s, our True North is to provide extraordinary family centered care.

- Integral to this goal is maintaining safety as our top priority.

- We maintain a blame free (non-punitive) culture so that ALL staff feel comfortable reporting safety-related events.

- Reporting allows our organization to assess our opportunities for systems improvement, so we can develop interventions to prevent future safety events and improve safety.

Example

A patient received 10 times the dose of oral methadone than what was ordered. The RNs miscalculated the dose and drew the dose from a bulk bottle in the Pyxis. The patient received the wrong dose and had to be transferred to a higher level of care to be monitored. Ultimately, the patient recovered without complications. The bedside nurse reported the event in the Quantros occurrence reporting system.

Through analyzing this error, a number of system fixes were implemented, including replacing bulk bottles of methadone in the Pyxis with 1 mL syringes. To have made the same error, the nurse would have had to pull out 7 syringes, a trigger that something is wrong with the calculation.
Quantros Occurrence Reporting System

• When a safety event occurs, it should be reported in Quantros
• When reporting events:
  – Think about the person reading the report; do they have enough information to understand what happened and to follow up?

Think SBAR!

S- Situation- What happened? What interventions were needed? Who did you tell?
B- Background- What contributed to the error (distractions, new product or procedure, etc.)?
A- Assessment- Was there harm? How often does this/could this happen?
R- Recommendation- What could be done to keep this from happening again?