Patient Safety Overview

- *Healthcare Safety*
- *How we address Patient Safety challenges*
- *Your role in improving Patient Safety*

Point #1 - healthcare is not as safe as it should be

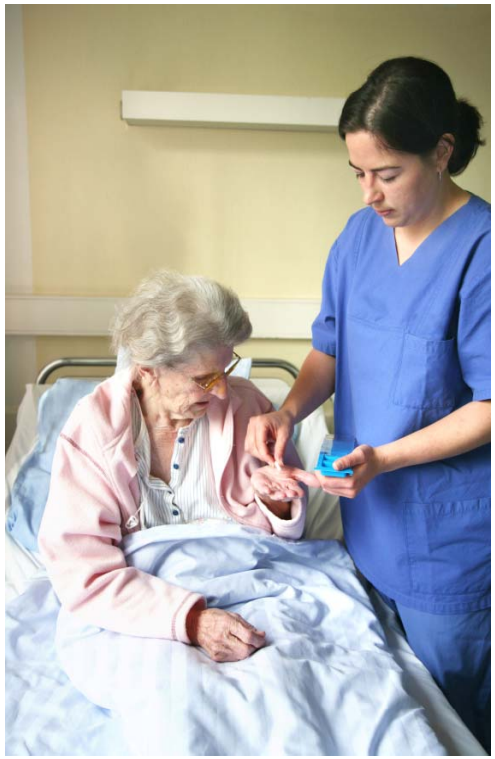
Up to 98,000 people die in U.S. hospitals each year as a result of medical errors. That's more than 268 people a day, or 11 people an hour.

This error rate is ***"roughly equivalent to a jumbo jet crashing every day."***

- Lucian Leape, MD, Harvard School of Public Health

Point #2 – how do we address challenges with patient safety?

…don't fix the blame, fix the problem!

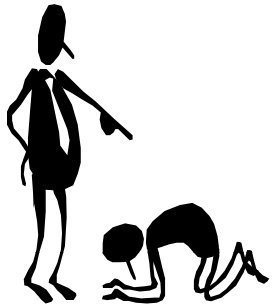


- 80% of our problems are caused by process/system design issues
- Only 20% of the time is it because a person "messed up"

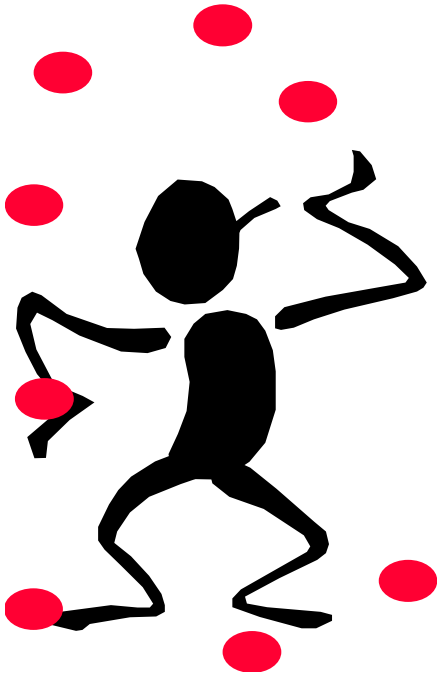
Most medical errors are committed by hardworking, trained individuals

Fix the problem by focusing on the Process:

- **Not on Person**
  - Do not shame and blame
  - It isolates unsafe acts from their process/system context



- **Instead on Process!**
  - Expect human fallibility and so build defenses
  - Concentrate on improving conditions under which people work!

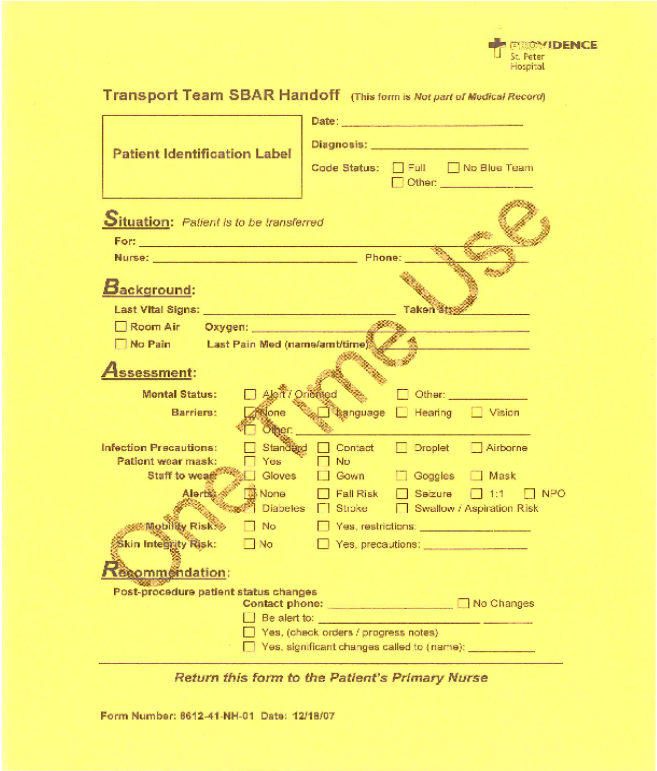


One example of focusing on the process: National Patient Safety Goals (NPSG)

- Developed to focus on most critical processes and preventable medical errors
- Selected by analyzing data related to unexpected/bad outcomes
- Every employee's responsibility to help keep patient's safe…regardless of job!

NPS Goal 2 - Improve the effectiveness of communication among caregivers

– *This SBAR form (Situation-Background-Assessment-Recommendation) is one example of how we improved communication when patient's are transported between various departments*



PROVIDENCE
St. Peter Hospital

Transport Team SBAR Handoff (This form is *Not part of Medical Record*)

Patient Identification Label

Date: _____
Diagnosis: _____
Code Status: ☐ Full ☐ No Blue Team ☐ Other: _____

Situation: *Patient is to be transferred*
For: _____
Nurse: _____ Phone: _____

Background:
Last Vital Signs: _____ Taken at: _____
☐ Room Air Oxygen: _____
☐ No Pain Last Pain Med (name/amt/time) _____

Assessment:
Mental Status: ☐ Alert / Oriented ☐ Other: _____
Barriers: ☐ None ☐ Language ☐ Hearing ☐ Vision ☐ Other: _____
Infection Precautions: ☐ Standard ☐ Contact ☐ Droplet ☐ Airborne
Patient wear mask: ☐ Yes ☐ No
Staff to wear: ☐ Gloves ☐ Gown ☐ Goggles ☐ Mask
Alerts: ☐ None ☐ Fall Risk ☐ Seizure ☐ 1:1 ☐ NPO ☐ Diabetes ☐ Stroke ☐ Swallow / Aspiration Risk
Mobility Risk: ☐ No ☐ Yes, restrictions: _____
Skin Integrity Risk: ☐ No ☐ Yes, precautions: _____

Recommendation:
Post-procedure patient status changes
Contact phone: _____ ☐ No Changes
☐ Be alert to: _____
☐ Yes, (check orders / progress notes)
☐ Yes, significant changes called to (name): _____

Return this form to the Patient's Primary Nurse

Form Number: 8612-41-NH-01 Date: 12/18/07

NPS Goal 7 - Reduce the risk of health care associated infections

- *It is <u>every person's</u> job to follow* ***hand hygiene guidelines*** *and* ***to wear proper barrier equipment***

Point #3 – your role is to notice Unusual Occurrences

Definition of Unusual Occurrence:

any happening which is not consistent with the routine care of a patient

Your responsibility:

Notify your preceptor/supervisor immediately if you witness an Unusual Occurrence, *then we can start process improvements*