Lucile Packard Children's Hospital AT STANFORD

Quality Outcomes & Patient Safety

PDCA | National Patient Safety Goals | Event Reporting

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

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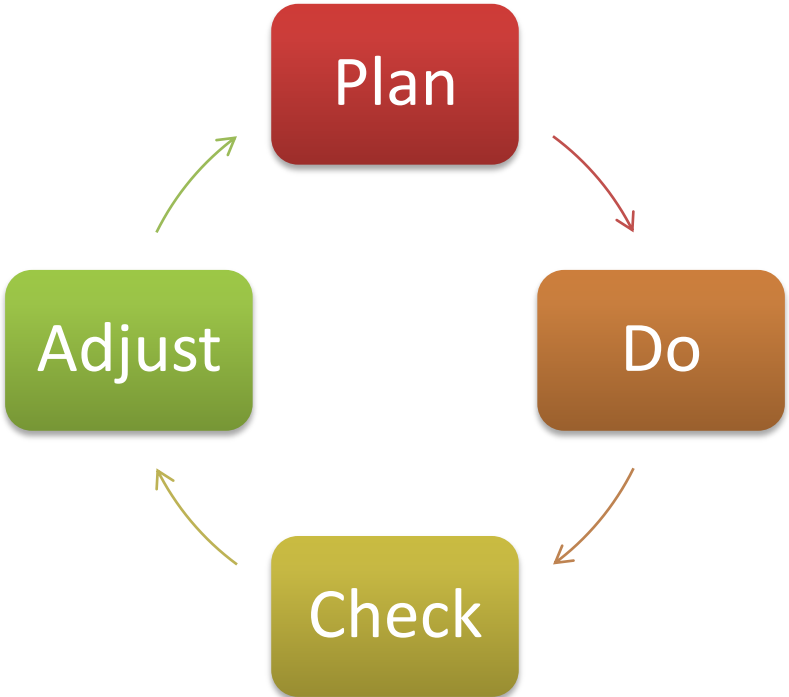
Quality Improvement Model

PDCA

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.



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National Patient Safety Goals

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 a 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

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Identify Patients Correctly

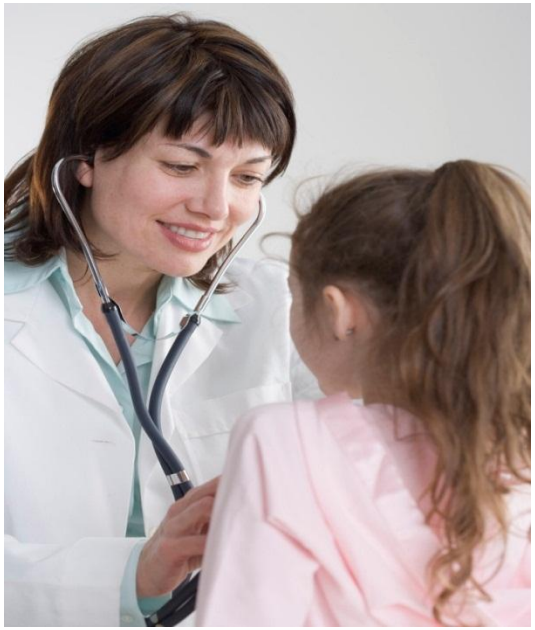
National Patient Safety Goals

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**



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Improve Staff Communication

National Patient Safety Goals

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 <u>one hour</u> 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.

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Use Medications Safely

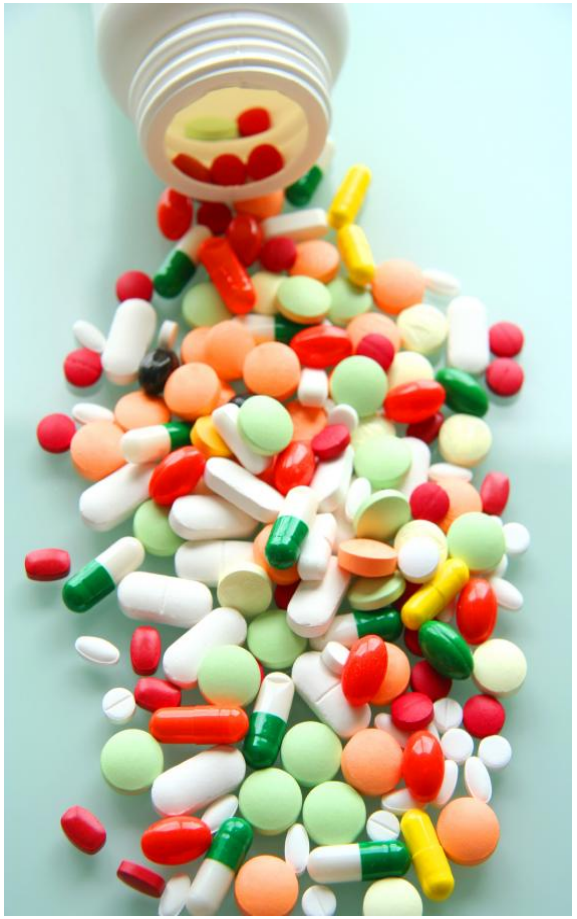
National Patient Safety Goals

- 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)

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Reduce Health Care- Associated Infections

National Patient Safety Goals

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)

Identify Patient Safety Risks

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.*

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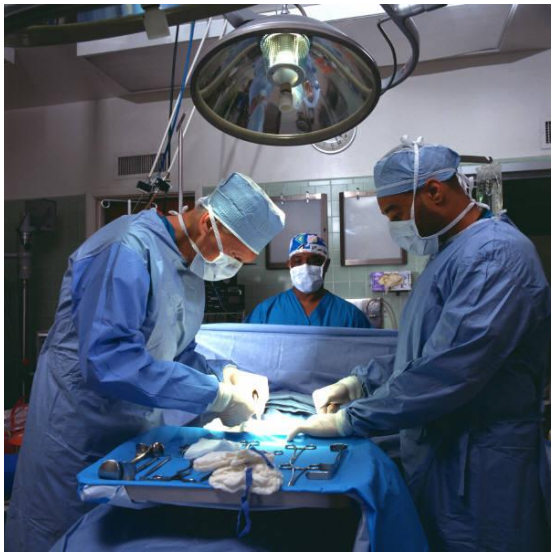
Prevent Mistakes in Surgery

National Patient Safety Goals

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

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Reporting Safety Events

Event Reporting

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**

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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.

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Quantros Occurrence Reporting System

Event Reporting

- 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?