CAROLINAS HEALTHCARE SYSTEM
BLUE RIDGE

Annual Continuing Education Modules

Patient Safety:

Carolina HealthCare System Blue Ridge

Patient Safety

This self-directed learning module contains information you are expected to know to protect yourself, our patients, and our guests.

Target Audience: **All Employees**

Contents

PATIENT SAFETY:

Instructions:

The material in this module is an introduction to important general information and procedures for patient safety. After completing this module, contact your supervisor to obtain additional information specific to your department.

- Read this module.
- If you have any questions about the material, ask your supervisor.
- Complete the online posttest for this module.
- The Job Aid on page 7 should be customized to fit your department's policies and procedures and then used as a quick reference guide.

Learning Objectives:

When you finish this module, you will be able to:

- Discuss the purpose of the Carolinas HealthCare System Blue Ridge Patient Safety program.
- Identify the "SAFER TOGETHER" components.
- Explain how to report a patient safety concern.
- Define a non-punitive environment.
- Identify The Joint Commission's National Patient Safety Goals.
- Identify the goals of the Hospital Engagement Network (HEN).

PATIENT SAFETY:

Patient Safety Program

CHS is committed to the safety of our patients. The purpose of the patient safety program is to eliminate patient harm associated with preventable adverse events and to improve the safety of care delivery through identification, analysis, and reduction of risk.

Patient Safety Definitions

- Patient Safety – Freedom from accidental injury or the degree to which the risk of an intervention and risk in the care environment are reduced for a patient, and other persons, including healthcare practitioners.
- Patient Safety Event – Any identified defect, error, medical accident, near miss medical accident, device failure, sentinel event, medication error, significant procedural variance, or other threat to safety that could or did result in patient injury.
- Near Miss – An occurrence or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention.
- Medication Error – Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer.
- Human Error – Inadvertently doing other than what should have been done, a slip, lapse, or mistake.
- National Patient Safety Goals (NPSG) – In 2002, The Joint Commission established its National Patient Safety Goals (NPSGs) program; the first set of NPSGs was effective January 1, 2003. The NPSGs were established to help accredited organizations address specific areas of concern in regards to patient safety.

PATIENT SAFETY:

At CHS, we believe we are "SAFER TOGETHER".

The "SAFER TOGETHER" program includes several components:

- Identifying risks for patient harm
- Reducing actual patient harm
- Encouraging a learning environment
- Creating a culture of safety

Your Responsibility:

Everyone is responsible for the safety of our patients. If you feel a patient's safety is at risk in your area, immediately report it to your supervisor or manager. Any staff member that identifies a patient safety concern has a duty to report it.

Examples of Patient Safety issues:

1. A patient without an armband
2. Failure to communicate important information with other healthcare team members
3. Medications that are not secure
4. Failure to use correct hand hygiene
5. Patients at risk for falls
6. Unlabeled medications on or off the sterile field
7. Incorrect patient identification

How to report a patient safety event, medication error, near miss, Adverse Drug Reaction (ADR) or unsafe condition:

- Fill out an Incident Report online within 24 hours of discovery, if not immediately via the Risk Web link on the hospital intranet.
  Online reporting allows for more complete and responsive tracking of events.

Non-Punitive Environment

- Carolinas HealthCare System Blue Ridge: Supports a non-punitive environment for reporting patient safety issues and medication errors in order to foster a culture of safety where we can learn from our experiences and reduce future risk to patients.

- Believes in examining our processes and systems of patient care as a risk reduction measure. We cannot improve unless we are aware of and carefully examine our issues.

- Believes in minimizing individual blame or retribution for involvement in a medical error.

- Believes staff is accountable for their behavioral choices.

PATIENT SAFETY:

The Joint Commission (TJC) National Patient Safety Goals

Everyone is responsible for helping meet *ALL* of these goals. TJC's 2013

National Patient Safety Goals:

- **Identify** patients correctly
- Improve staff **communication**
- Use **medications** safely
- Prevent **Infections**
- Identify patient **safety risks** (identify individuals at risk for suicide).
- Prevent **mistakes** in **surgery** (Universal Protocol)

The Hospital Engagement Network (HEN)

- As a key component of the Partnership for Patients, CHS was selected by the Centers for Medicare and Medicaid Services to be one of 27 Hospital Engagement Networks (HEN) nationwide
- All CHS hospitals have committed to full participation
- Intent is to achieve the goals of the Partnership for Patients (PfP) by the end of 2014
    a. **40% reduction in hospital acquired conditions**
        - Adverse Drug Events
        - Catheter-Associated Urinary Tract Infections (CAUTI)
        - Central Line Bloodstream Infections (CLABSI)
        - Injuries from Falls and Immobility
        - Obstetrical Adverse Events
        - Pressure Ulcers
        - Surgical Site Infections
        - Venous Thromboembolism
        - Ventilator-Associated Pneumonia

    b. **20% reduction in preventable readmissions**

PATIENT SAFETY:

The **CHS HEN** seeks to engage facilities through discussions, support and culture change through its internal Quality Safety and Operations Councils (QSOCs™).

The purpose of QSOC™ is to serve as a System-wide collaborative platform to envision, drive and integrate quality and patient safety excellence across CHS facilities.

CHS Quality has over 20 QSOCs established across the System, the relevant QSOCs™ working on HEN focus areas include the following:

- Medication Safety,
- Infection Prevention and Control,
- Patient Safety/Falls, Pressure Ulcer Prevention,
- Labor & Delivery,
- Surgery,
- VTE and
- Readmissions.

Each QSOC™ addresses a single focus area with the exception of Infection Prevention and Control, which addresses CAUTI, CLABSI and VAP.

QSOCs™ also help to manage and improve quality and patient safety outcomes.

PATIENT SAFETY:

JOB AID

1 *The purpose of the patient safety program is to eliminate patient harm associated with preventable adverse events at CHS and to improve the safety of care delivery through identification, analysis, and reduction of risk.*

2 *A near miss is a category used to describe conditions that could have harmed patients but did not.*

3 *The Joint Commission's 2013 National Patient Safety Goals are:*

- *Improve the accuracy of patient identification*
- *Improve the effectiveness of communication among caregivers*
- *Improve the safety of using medications*
- *Reduce the risk of health care-associated infections*
- *Identify safety risks inherent in its patient population (identifies individuals at risk for suicide)*
- *The organization meets the expectations of the Universal Protocol to prevent errors in surgery (Right site, right procedure, right patient)*

4 *Examples of patient safety issues include:*

- *A patient without an armband*
- *Failure to communicate important information with other healthcare team members*
- *Medications that are not secure*
- *Failure to use correct hand hygiene*
- *Patients at risk for falls*
- *Unlabeled medications on or off the sterile field*
- *Incorrect patient identification*

5 *If a patient's safety is in danger in your area, immediately report it to your supervisor or manager. Any staff member identifying a patient safety concern has a duty to report it.*

PATIENT SAFETY:

6 *The intent of the Hospital Engagement Network (HEN) is to reduce* hospital acquired conditions by 40% and preventable readmissions by 20%.

7 *The hospital acquired conditions the HEN has identified for the 40% reduction include:*

- *Adverse Drug Events*
- *Catheter-Associated Urinary Tract Infections (CAUTI)*
- *Central Line Bloodstream Infections (CLABSI)*
- *Injuries from Falls and Immobility*
- *Obstetrical Adverse Events*
- *Pressure Ulcers*
- *Surgical Site Infections*

8 *The mission of CHS Patient Safety QSOC™ (Quality and Safety Operations Council) is to foster a safe environment for patients throughout Carolinas HealthCare System.*