Patient Safety

Annual Compliance Education

This course contains annual compliance education necessary to meet compliance and regulatory requirements.

Instructions:

To receive credit for completion:

1. Read the content in full.
2. Complete the online exam.

Carolinas HealthCare System

Last Revised: 06/12/15

Patient Safety

Welcome

Purpose:

Introduce patient safety steps you are expected to know to protect yourself, our patients and visitors. When you complete this course, contact your leader to get more information about patient safety in your department.

Learning Objectives:

When finished with this course, you should be able to:

- Describe the Carolinas HealthCare System (CHS) Patient Safety Program and the key parts of the "Safer Together" Program
- Describe how to report a patient safety concern
- Define a non-punitive environment
- Describe the Joint Commission's National Patient Safety Goals and what is a "sentinel event"
- Describe the role of Quality and Safety Operations Councils™

Patient Safety

Patient Safety Program

CHS is committed to the safety of our patients.

The purpose of the patient safety program is to:

- Get rid of patient harm caused by bad events that can be prevented
- Improve care delivery through reducing risk

Patient Safety

Patient Safety Event

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 Safety Event

A deviation from generally accepted performance standards that does not reach the patient (the error is caught by a detection barrier or by chance)

Precursor Safety Event

A deviation from generally accepted performance standards that reaches the patient and results in minimal harm or no detectable harm

Serious Safety Event

A deviation from generally accepted performance standards that reaches the patient and results in moderate to severe harm or death

Medication Error

Any preventable event that may cause or lead to inappropriate medication use or patient harm while medication is in the control of the healthcare professional, patient or consumer

Human Error

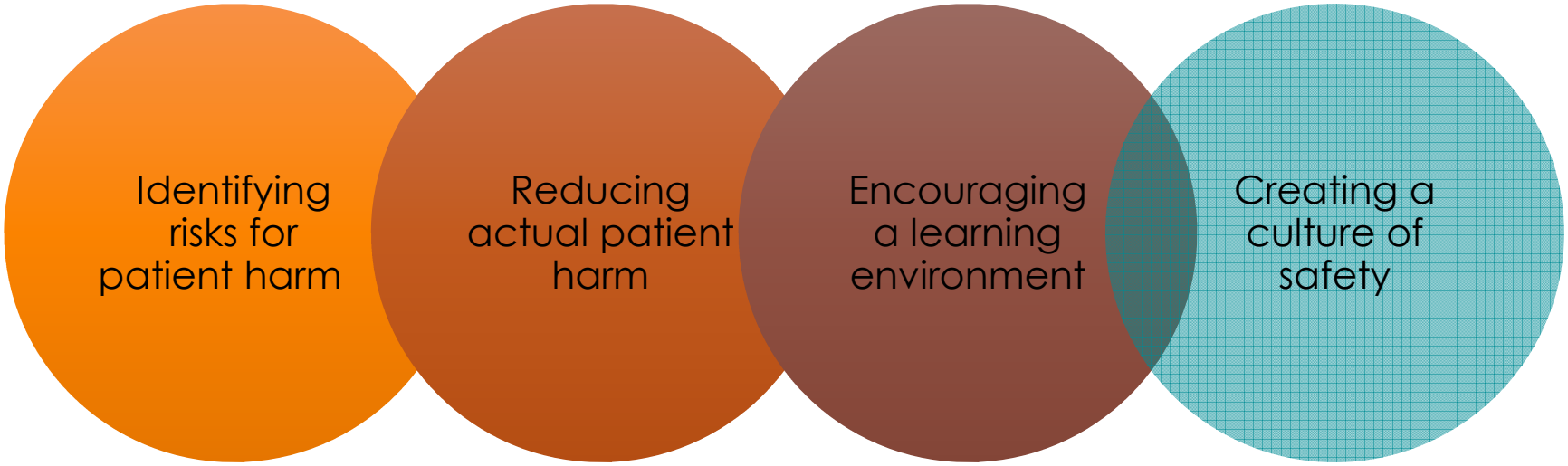
Inadvertently doing something other than what should have been done such as as a slip, lapse or mistake

Patient Safety

The "Safer Together" Program

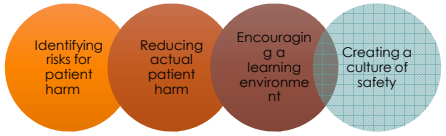
At Carolinas HealthCare System (CHS), we believe we are "Safer Together"

The "Safer Together" Program includes several components:



Patient Safety

"Safer Together": Your Responsibility



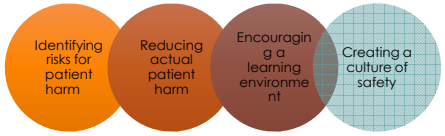
Everyone at CHS is responsible for the safety of patients.

- Any teammate that sees a patient safety concern has a responsibility to report it
- If you believe that a patient's safety is at risk, immediately report it to your leader

Examples of Patient Safety Issues:
Incorrect hand hygiene
Patient has a severe allergic reaction to a medication administered
Important information is not communicated to other healthcare team members
Medications that are not secure
Patients at risks for falls
Unlabeled medications on or off the sterile field
Incorrect patient identification

Patient Safety

How to Report a Patient Safety Event



Report a patient safety event or unsafe situation by:

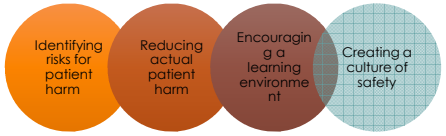
Filling out a Care Event Report immediately. If this cannot be done immediately, it must be done within 24 hours of discovery. This report can be found online through the Concern and Incident Reporting link on PeopleConnect.

http://peopleconnect.carolinas.org/tools-1088

Online reporting allows for more complete tracking of events

Patient Safety

Non-Punitive Environment



Carolinas HealthCare System (CHS) supports a non-punitive environment for reporting patient safety issues and medication errors. This fosters a culture of safety where we can learn from our experiences and reduce future risk to patients.

- CHS 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.
  - Minimizing individual blame or retribution for involvement in a medical error
  - Holding teammates accountable for their behavioral choices

Patient Safety

The Joint Commission (TJC) National Safety Goals

The National Patient Safety Goals (NPSG) were written to help healthcare organizations deal with patient safety concerns. Each year, The Joint Commission decides the main patient safety issues and how to best address them.

TJC's National Patient Safety Goals:

Identify patients correctly	Improve the safety of medical alarm systems	Prevent mistakes in surgery (Universal Protocol)
Improve teammate communication	Prevent infections	Reduce the risk of falls (Home Care and Nursing Care Centers only)
Use medicines safely	Identify patient safety risks (including risk for suicide)	Prevent healthcare-associated pressure ulcers (Nursing Care Centers only)

For more about the NPSGs, click on the link below:
http://www.jointcommission.org/standards_information/npsgs.aspx

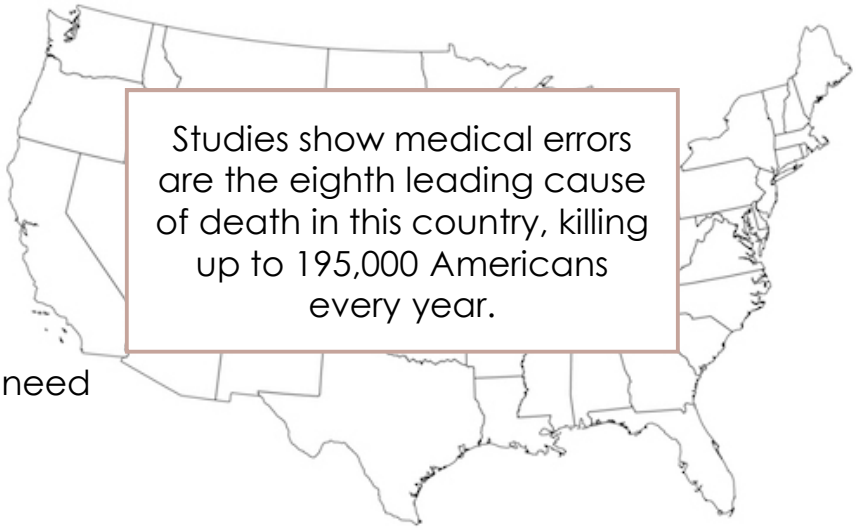
NOTE: CHS applies NPSGs in some work areas that are not surveyed by Joint Commission. This is because the NPSGs are good, safe patient practices.

Patient Safety

The Joint Commission (TJC) Sentinel Events

Despite the hard work ongoing nationwide to analyze and improve healthcare systems and processes for patient safety, severe errors or sentinel events still occur. They can happen in any facility at any time.

Sentinel events are so named because they indicate the need for immediate investigation and response.



TJC defines sentinel event as:
"A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm or severe temporary harm."

NOTE: The definition has been expanded beyond patients to include rape, assault (leading to death, permanent harm or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization.

Other types of events that reach patients, visitors and staff are considered sentinel events. Review a complete list of sentinel events here:
http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/

Patient Safety

Sentinel Events: Your Responsibility

All teammates are responsible for reporting sentinel events:

1. If a sentinel event happens in your work area, immediately report it to your leader
2. After telling your leader, complete an online Care Event Report. This can be found at: http://peopleconnect.carolinas.org/tools-1088

Any team member identifying a sentinel event must report it immediately.

Patient Safety

Quality and Safety Operations Councils (QSOC™)

A QSOC™ is a system-wide sharing of ideas driving quality and patient safety excellence at Carolinas Health Care System (CHS).

Benefits of participating in QSOC™:

- Learning from each other
- Sharing of knowledge with other system experts
- Sharing of best practices
- Enabling spread and rapid replication
- Building high reliability
- Networking with "like" peers
- Prioritizing what is important

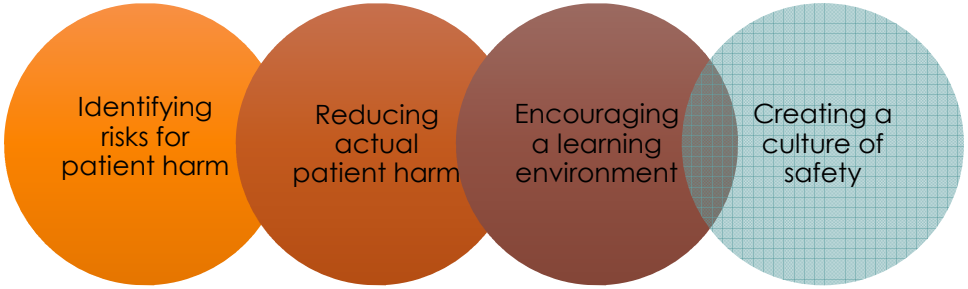
CHS Quality has 20 QSOC™s established across the system. These councils work on things like Medicine Safety, Infection Prevention and Control, Patient Safety, Falls, Perinatal (childbirth and newborn care), Surgery and Readmissions (patients returning to the hospital.)

Patient Safety: Job Aid

Purpose: Use this job aid to reference important information regarding patient safety.

The patient safety program helps to eliminate patient harm associated with preventable adverse events at Carolinas HealthCare System and improve the safety of care delivery through identification, analysis and reduction of risk.

"Safer Together" Components



A **near miss** describes conditions that could could have harmed patients but did not.

Any teammate identifying a patient safety concern has a responsibility to report it. If a patient's safety is in danger, immediately report it to your leader.

TJC's National Patient Safety Goals:

Identify patients correctly	Improve the safety of clinical alarm systems	Prevent mistakes in surgery (Universal Protocol)
Improve staff communication	Prevent infections	Reduce risk of falls (Home Care and Nursing Care Centers only)
Use medications safely	Identify patient safety risks	Prevent pressure ulcers (Nursing Care Centers only)

Examples of Patient Safety Issues:
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NOTE: The definition has been expanded beyond patients to include rape, assault (leading to death, permanent harm or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization.

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Patient Safety

Summary

A Patient Safety Event is any identified defect, error, medical accident, near miss medical accident, device failure, sentinel event, medication error, significant procedural variance or other safety threat that could or did result in patient injury.

Everyone at Carolinas HealthCare System (CHS) is responsible for the safety of the patients.

The following are some key items reviewed in this course:

- The CHS Patient Safety Program and the key parts of the "Safer Together" Program
- How to report a patient safety concern
- A non-punitive environment
- The Joint Commission's National Patient Safety Goals and what is a "sentinel event"
- The role of Quality and Safety Operations Councils™