Tips in International Patient Safety Goals

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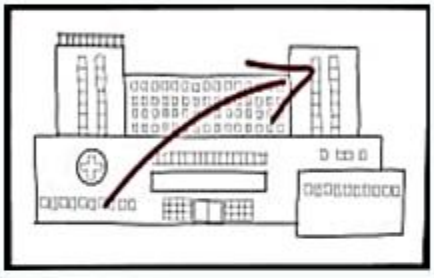
1st IPSG: Identify Patient correctly

Frist contact with patient

You must identify patient correctly at these risky times

Before any care activities for patient

Patient Endorsement



Patient Transfer

Use at least two main identifiers

1- Patient's full name

2- Medical record number (MRN).

Neonates must to be wear Two ID bands (Rt. Hand & Lt.leg) and one contains Mother's 3 names and MRN

Twins labelled „Twin 2", „Triplet 3" etc.

Patient without proper identification e.g.(no national ID, incomplete papers

Use temporary identifiers as (name : unknown (number) + MRN), till completing patient identification papers

Sampling

labeling of containers used for blood and other specimens in the presence of the patient before sampling

Patients with Similar names :

1-Separate those patients in different rooms as possible

2- Caution stickers with „Caution, there is another patient with the same name" must be used on notes and medication charts and pt. file

3-Send email to stakeholder e.g. (pharmacy, lab, medical record,...) to take care about errors

Patient ID & wristband :

✓**Reviewing:** Accurate patient identification starts with the patient's first contact by reviewing admission papers.

✓**Removal:** Must **not be** removed until the patient discharged outside the hospital.

✓**Replacement:** If the patient wristbands are removed, faded, damaged or unreadable, replacement wristbands **MUST** be applied immediately, by the nurse caring for the patient.

✓**Monitoring:** In charge nurse ensures all inpatients on their unit are wearing approved forms of identification at each shift.

✓Assigned nurse checks ID wristband frequently.

✓**Dead patients** must be identified with two ID bands, on opposing limbs i.e. (one on the right wrist and on the left ankle where possible).

Remember. Wrong or misidentification of patient, will lead to serious outcomes:

Safety issues
Physical harm wrong decision, procedure or even death

COST
Procedures for wrong patients increase unnecessary cost

Medico-legality
Improper identification put you and organization in medicolegal risk

Patient satisfaction
Lead to patient dissatisfaction. Negative organization reputation

2nd IPSG: Improve effective communication

Verbal Order

- Must be used for urgent/emergency situations, or when the physician is scrubbed only
- NOT acceptable For narcotics, chemotherapy, blood and blood products.
- Must be countersigned and stamped by ordering physician as soon as the case is over.
- Must be only from physician who handling the case.
- Only one dose is prescribed verbally.

Telephone Order

- Must be given only in a situation where the doctor is not immediately available and immediate patient care Intervention is required.
- NOT acceptable For high alert medication, narcotics, chemotherapy, blood and blood products.
- For routine orders are not accepted over the telephone

Panic(Critical) Results Reporting

- Verbal communication of results must be documented in the "panic Value logbook" Include:

✓Name of the personnel reporting the result.

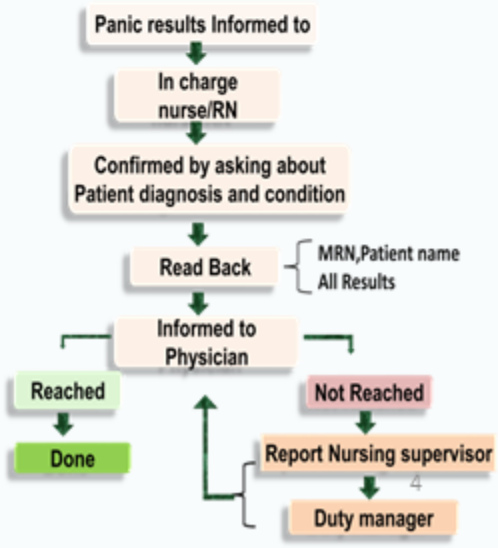
✓Name of the test/procedure and the result.

✓Name of the staff receiving the result.

✓Date & Time Result was reported.

- Notification to the physician within (10) min or specific time according to your hospital internal policy and immediately for life threatening result.

Critical result reporting and Communicating Critical Test Results/Values (reporting chain) :



Patient Handover

- **Intra hospital :** patient moves to a new unit.
- Use patient transfer form.
- **Out side hospital**: patient moves to another health care facility.
- Use patient external transfer form.

- **Patient Endorsement :**
- Shift to shift process in same unit.
- face to face between nurses.
- Use patient flow sheet & other patient data.
- Shift Reports, Attachment, will be verbal and written.

- Patients with multiple lines, IV infusions and all critical units' patients the endorsement must be bed side.
- **Both handover & endorsement must be complete and comprehensive include:**

✓Patients' details, diagnosis,Specific ongoing treatment or care needs

✓Medication and infusions that are in progress

✓Equipment that is required to assist in the patient's care.

✓Details of any incidents or injury that has occurred during the current inpatient episode, social situation and discharge plans.

The ISBAR used for providing a standardized exchange of information:

I — **Identify**
- ✓ Yourself/role/location/Client's details: name/MRN/gender/age

S — **Situation**
- ✓ What is going on with the patient. State if the situation is urgent
- ✓ Identify current symptoms and clinical needs.

B — **Background**
Primary diagnosis and relevant secondary diagnoses, current medications, laboratory results / diagnostic studies, allergies, interventions and procedures.

A — **Assessment**
- ✓ Provide your observations and evaluations of the patient's current state.
- ✓ Explain recent anticipated changes in condition and treatment.

R — **Recommendation**
Explain what you think needs to be done.
Follow-up Care / issues requiring ,Orders, Pending treatment / tests& Issues / items left undone that require follow- up

3rd IPSG : Improve Safety Of High Alert Medications

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error.

To Improve Safety Of High Alert Medications they must be:

- ✓ **Labeling with high alert medications.**
- ✓ **Ensure the label did not cover the information written on the product's label.**

- ✓ **Physically separated from other medications.**
- ✓ **High-alert medications should be stored in individual containers**

- ✓ **Keep it in locked location.**
- ✓ **Double check by 2 nurses before administration.**
- ✓ **Monitor and report adverse drug reaction and medication error related to high alert medications.**

Look Alike medication:

Medications that have similar appearance but different in name and actions.

Examples:

Heparin vs Atropine

Primperan vs Avil

Sodium Bicab 25ml vs magnesium sulfate 2.5 g

Sound Alike medication:

Medications that have similar names but different in actions and uses .

Examples:

DepreBAN(antidepressant) vs DepriVAN (general anesthesia)

Depakine (anticonvulsant) vsDebocaine(lidocaine(local anesthesia)

Concentrated Electrolytes/ solutions

Potassium chloride

magnesium sulfate

Calcium chloride

Dextrose 25% or higher

Hypertonic saline 3% ...etc

Narcotics/Opoids /sedative agents

(IV, Oral, transdermal,...etc)

Morphine

Fentanyl

chloral hydrate

Midazolam

Ketamine,...etc

FOR ISMP List Of High-alert Medications 2024
Scan QR Code

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4th IPSG: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery

Surgical and invasive procedures include all procedures involving an incision or puncture, including, but not limited toopen surgical procedures, percutaneous aspiration, selected injections, biopsy percutaneous cardiac and vascular diagnostic or interventional procedures, laparoscopies, and endoscopies.

PRE-PROCEDURE VERIFICATION

1st step:

- **Obtain Consent form included:**
- **Patient's full name & MRN.**
- **Name of procedure.**
- **Site of procedure.**
- **Pre-anesthesia assessment & anesthesia consent.**
- **Pre operative checklist**
- **Prepare needed radiological & lab studies**
- **verify that any required blood products, special medical equipment, and/or implants are present.**

2nd step:

- **Marking the site of the procedure**

✓ **Done by the responsible surgeon.**

✓ **Required for procedures involving right/left distinction , multiple structures (fingers and toes).**

✓ **The mark is made at or near the procedure site.**

✓ **The mark is sufficiently permanent to be visible after skin preparation and draping.**

✓ **involving the patient in the marking process**

✓ **For nonsurgical invasive procedures, it may be a general physician who will do the procedure. The hospital should identify who is authorized to perform surgical site marking in policy and procedure, or medical staff governing documents**

Intra Operating Theatre

Sign in

Before induction of anesthesia

Confirm and check :

- ✓ Patient identification
- ✓ Surgical site & Site mark
- ✓ Name of procedure
- ✓ Signed informed consent
- ✓ Patient's known allergy
- ✓ Prosthesis/special equipment

Time out

Before skin incision

- ✓ Confirm Pt. full name &MRN
- ✓ Name of surgery (procedure)
- ✓ Side & site mark / if applicable
- ✓ Confirm all team members have introduce themselves by name and Role.
- ✓ Confirm completeness & readiness of (instruments & supplies).
- ✓ Confirm blood reservation / if applicable
- ✓ Confirm allergy type (if applicable)
- ✓ Confirm allergy test & antibiotics dose (if applicable)
- ✓ Recording & documented time of start &finish surgical procedure in (sheet & operation board)

Sign-out

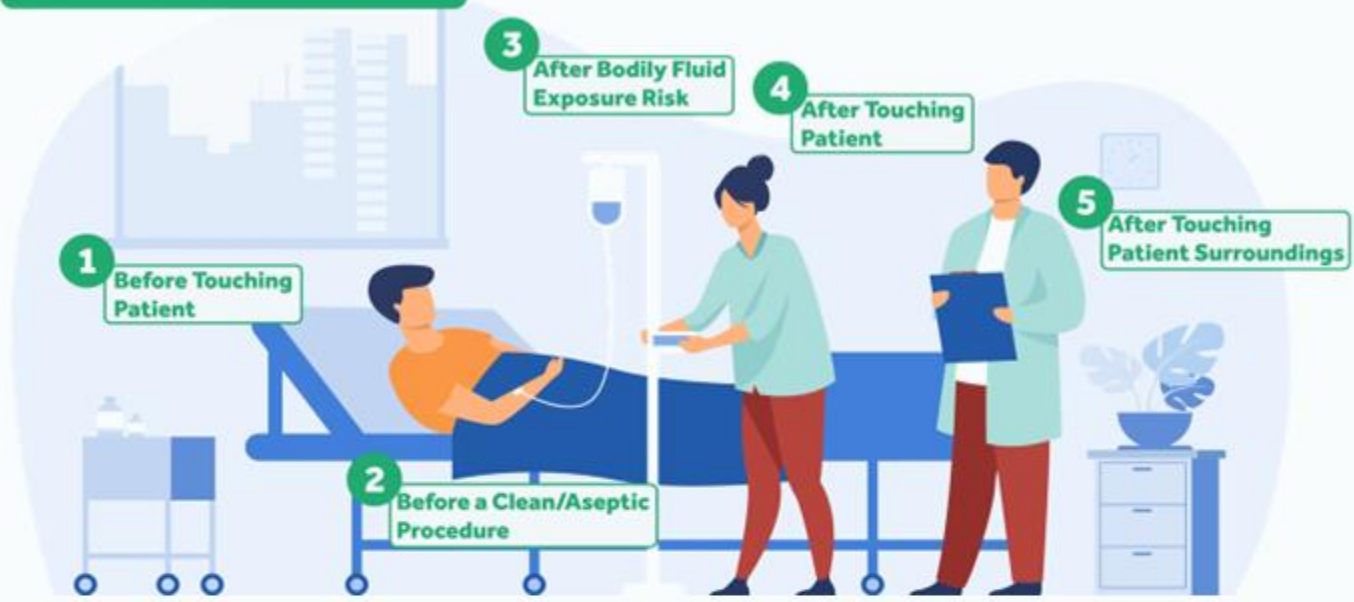
Before patient leaves operating room

Nurse verbally confirms with the team:

- ✓ The name of the procedure recorded
- ✓ That instrument, sponge, needle and other counts are correct
- ✓ The specimen is labelled (including patient name)
- ✓ If there are any equipment problems to be addressed
- ✓ Surgeon, anesthesia professional and nurse review the key concerns for recovery and management of this patient

5th IPSG: Reduce the Risk of Health Care-Associated Infections

5 Moments of Hand Hygiene for Healthcare Workers



Hand Washing

PPE & Isolation Precautions

Contact precautions

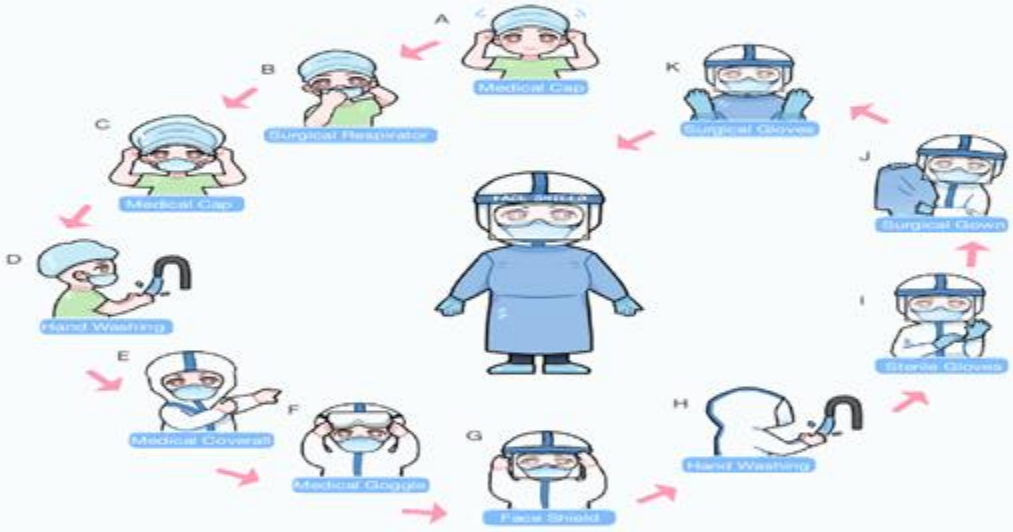
- Use the following measure in addition to standard precautions when in contact with individuals known or suspected of having diseases spread by direct or indirect contact (examples include norovirus, rotavirus, draining abscesses, head lice).

Droplet Precautions

- In addition to standard precautions, wear a surgical mask and eye goggles when within 1 m (1.5 m for smallpox) of persons known or suspected of having diseases spread by droplets (examples include influenza, pertussis, meningococcal disease).

Airborne Precautions

- Use the following measures in addition to standard precautions when in contact with individuals known or suspected to have diseases spread by fine particles dispersed by air currents (examples include tuberculosis, measles, and SARS)



Reduce Healthcare-Associated Infections (HAIs)

VAP bundle

- ✓Head-of-bed elevation between 30° and45°
- ✓Daily "sedation vacation" and a readiness-to-wean assessment.
- ✓Peptic ulcer disease prophylaxis. Deep vein thrombosis prophylaxis.
- ✓Daily oral care with chlorhexidine

CAUTI bundle

- ✓Daily surveillance regarding further need of catheter
- ✓Maintenance of free urine flow
- ✓Proper securing of catheter on body
- ✓Urine bag below the level of urinary bladder and not on the floor
- ✓Maintenance of closed sterile drainage tubes
- ✓Aseptic techniques for obtaining urine samples / sampling port
- ✓Urinary catheter and connection tube care

CLABSI bundle

<u>Daily maintenance and monitor care</u>

- ✓Daily review of line necessity.
- ✓ Use only sterile devices to access catheters.
- ✓ Immediately replace dressings that are wet, soiled, or dislodged.
- ✓ Perform routine dressing changes using aseptic technique.
- ✓ Scrub the access port or hub with friction immediately prior to each use with an appropriate antiseptic (chlorhexidine, or 70% alcohol)

6th IPSG :Reduce harm caused by diagnostic errors .

Diagnostic errors are one of the leading causes of preventable harm in health care, and hospitals have a responsibility to minimize harm to their patients by identifying and addressing causes of diagnostic errors.

It may be:

A delayed diagnosis

refers to a case where the diagnosis should have been made earlier.

Delayed diagnosis of cancer is by far the leading entity in this category.

A wrong diagnosis for example, if a patient truly having a myocardial infarction is told their pain is from acid indigestion. The original diagnosis is found to be incorrect because the true cause is discovered later.

A **missed diagnosis** refers to a patient whose medical complaints are never explained. Many patients with chronic fatigue, or chronic pain fall into this category, as well as patients with more specific complaints that are never accurately diagnosed

Factors leading to diagnostic errors include

- Diagnostic complexity
- Breakdowns in communication or care coordination
- Lost test results
- Equipment malfunctions
- Availability of specialty clinicians.

Areas of focus for diagnostic errors include:

- Screening and diagnostic radiology
- Pathology
- Laboratory (infectious disease/microbiology, newborn disease screenings – including metabolic disorders, and results indicative of disease processes with or without signs and symptoms)

- Care coordination (delayed communication – other health care practitioners and patients, patient return after having been seen, patient appointments

Methods to minimize diagnostic errors

✓ **Closed-loop communication :**

- It means every test result is always sent, received, acknowledged, and acted upon.
- Establish standardized processes to ensure timely communication of abnormal test results to a clinician responsible for follow-up care.

✓ Optimize health information technology (IT) capabilities to communicate test results.

✓ **Conducts an intensive analysis** for causes of diagnostic error in the selected focus area(s).

✓ **Implements evidence-based interventions** based on data analysis with the intent to improve the diagnostic area(s) of focus.

✓ **Evaluates the effectiveness of the intervention(s)** for improvement of the diagnostic area(s) of focus.

Educate and supports clinical staff on diagnostic errors that includes at minimum:

a) The definition of diagnostic error

b) The causes of diagnostic errors

c) Time frames for responses and follow up

d) Procedure to report diagnostic errors

e) Clinical education and resources when cognitive errors are involved in diagnostic errors

f) A “no blame” and “learning” culture with systems focus when diagnostic errors occur

Reference: JCI Accreditation Standards for Hospitals and Academic Medical Centers (AMC), 8th Edition