ESSENTIAL ELEMENTS OF PATIENT SAFETY

A recent one month U.S. government study revealed that:

- **13.5% of hospitalized Medicare patients experienced at least one serious adverse event**
- **1.5% experienced an adverse event that contributed to their death**
- **44% of adverse events were preventable**
- **The one month cost to Medicare of adverse events was $324 million (equivalent to $4.4 billion per year)**

The patient population of our LA County health system is generally younger than Medicare age, but due to other adverse socioeconomic factors that contribute to increased severity of illness, we can assume that our statistics are probably comparable. Thus there is great opportunity to protect our patients from the unintended harm that might result from our highly complex system of healthcare.

Los Angeles County Department of Health Services (LA County DHS) leadership, in collaboration with the DHS Patient Safety Committee, is providing this guide to the basic elements of safe patient care so that all clinical staff shares a common knowledge base. Included in this curriculum are Joint Commission patient safety goals and standards, California Department of Public Health (CDPH) safety requirements, and other important topics that will guide patient safety practices across all facilities. Provided here is a brief overview of the essential principles. As a reference source, the current Joint Commission National Patient Safety Goals and the list of CDPH-reportable events are appended at the end of this patient safety guide.

Some patient safety topics may not be applicable to all sites. Hospitals, MACCs and clinics may have policies and procedures to customize these elements to meet their individual needs and structure.

Some definitions:

- *Patient Safety*: Freedom from unjustified risk and preventable harm
- *Adverse Event*: An injury caused by medical management rather than by the underlying disease or condition of the patient
- *Near Miss (or Close Call)*: Any mistake or system failure that was identified and resolved before reaching the patient
- *Error*: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim, with actual or potential negative consequences for the patient
- *Sentinel Event*: An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof (for further details, see Joint Commission standards). These events require immediate investigation and response
- *California Department of Public Health (CDPH) Reportable Event*: CDPH has identified a list of events that are usually preventable and should not happen in the hospital setting (see Appendix III). Facility risk managers will ensure that all staff members know to immediately report these events, as CDPH must be notified within a strictly limited time frame.

Reporting:

Adverse events, near misses, and errors will happen in any complex organization. In addition to preventing or minimizing patient harm from these occurrences, the goal is to learn from them so that they are less likely to be repeated. Use the Patient Safety Network (PSN) for reporting adverse events, near misses, errors, sentinel events, and CDPH-reportable events. These reports are a valuable resource for us to learn about patient harm at our facilities. **It is the responsibility of every individual to report a patient safety occurrence, whether or not it reached the patient and whether or not it caused harm.** Facility risk managers will provide guidance about reporting through PSN, and are responsible for meeting requirements for Sentinel Events and CDPH-reportable events.

Educate patients and families about how they can report concerns related to patient safety before, during or after care is provided. These concerns may be reported to the hospital, to DHS via a hotline or e-mail, to The Joint Commission, or to The Medical Board of California. Signs are posted where patients and families can be informed about avenues to report their concerns.

Safe and Just Culture:

The healthcare environment is one in which the occurrence of error is recognized as inevitable, often as a result of flawed, complex systems. A Safe and Just Culture is one in which patient safety is an individual and organizational priority. The reporting of errors, near misses, and adverse events is simple and is encouraged. These are viewed as opportunities to identify and improve processes of care.

Individuals are accountable for their own performance in accordance with their job responsibilities and DHS core values, but they do not carry the burden for system flaws over which they have no control.

Corrective or disciplinary action may be reserved for

- Behavior that knowingly puts patients, visitors or staff at risk for harm
- A conscious disregard for organizational policies and procedures
- Behavior that is disruptive to the workplace environment
- Repetitive errors or behavior that demonstrates an inability to fulfill legitimate work requirements

Simple human errors, and behaviors where risk is not recognized (or is mistakenly believed to be justified), will be individually evaluated with the focus not on discipline, but on understanding the reasons for errors and on creating the proper incentives for behavioral modifications.

See: DHS Policy #311.4 - Safe and Just Culture

Disruptive Behavior:

Disruptive behavior is behavior that interferes with teamwork or safe patient care, or has the effect of intimidating or suppressing legitimate input by others. It can be obvious, such as angry outbursts, throwing objects, or use of disrespectful language. It can also be passive, as in failing to engage in necessary work communication or not performing assigned tasks.

Disruptive behavior creates unsafe conditions, and it is the expectation that all staff will conduct themselves in a courteous, cooperative and professional manner. Disruptive, inappropriate, or unprofessional behavior should be reported, and any corrective action will be reflective of the nature and severity of the incident or prior patterns of behavior.

See: DHS Policy #747.300 - Workforce Behavioral Expectations

Patient Identification:

Use at least **two identifiers** for each patient when administering medications, blood or blood products, taking blood samples or other specimens, or providing treatments or procedures. Combinations of patient name, medical record number and/or date of birth are typically used.

Never use a patient's bed, room number or other location as an identifier.

Conscious patients, who are able, should help to identify themselves by telling you their name.

Promptly label containers for blood or other specimens in the presence of the patient to avoid applying the wrong patient's label.

When **transfusing blood or blood components**, match the blood or blood component to the physician order and blood bank paperwork, and match the patient to the blood or blood component. Use a two-person identification process (or a one-person identification process accompanied by automated identification technology such as bar coding when this becomes available). When using a two-person identification process, one person is the qualified transfusionist who will be administering the blood or blood

component and the second individual is qualified to participate in the process (as defined by the facility).

Communication:

Write down and "**read back**" verbally transmitted orders or test results to ensure accuracy. Exceptions would be during emergency situations (e.g. Code Blue) or during surgery when "**repeat back**" may be more appropriate.

Certain **abbreviations or dose expressions** are frequently misinterpreted and are thus not permitted in orders, preprinted forms, or in other documentation related to medications (handwritten or electronic). Although some facilities will have additional unapproved abbreviations, the basic list of unapproved abbreviations includes:

UNAPPROVED ABBREVIATION	CORRECT DESIGNATION
U, u	Unit
IU	International Unit
Q.D., QD, q.d., qd	Daily or Every day
Q.O.D., QOD, q.o.d., qod	Every other day
Trailing zero when used in relation to medications (xo)	x mg
Lack of leading zero (.x mg)	o.x mg
MS	Morphine or Morphine sulfate
MSO_4	Morphine or Morphine sulfate
$MgSO_4$	Magnesium or Magnesium sulfate

You will be able to access standardized abbreviations, dose expressions, terminology and other definitions that are approved for use at each facility.

Facilities will determine what potentially life-threatening, **critically abnormal results of tests or diagnostic procedures** require prompt notification of the responsible caregiver within a defined time frame. Processes are in place to ensure timely notification, which should be documented.

Transitions of care represent serious threats to patient safety due to the potential loss of important information during the handoff process. **Handoff communication** within each facility, at every level, should be well defined and appropriate in content to the complexity of the care transition. Be sure to provide the opportunity for discussion between the giver and the receiver of patient information during the handoff process.

Effective communication with patients is essential to safe care. Ask patients to "**teach back**" the important elements of what was communicated to them.

Medication Safety:

High-alert medications are those that carry a greater risk for errors or significant adverse events. Each facility has a list of identified high alert medications, and a process for managing these medications that may be different from other drugs. These processes often include nursing double checks before administration. With this process, the double check is an active process whereby both nurses independently check the order, the drug, the dose calculation, the amount of medication to be administered, the route of administration, the infusion pump setting, as well as the patient's identity. Other methods of handling high-alert medications might include restricting the areas in which the medications can be administered, limiting the providers who are permitted to order them, reducing the number of drug concentrations available, employing special protocols to guide their use, providing separate storage, using commercially prepared premixed solutions, and labeling medications in a distinctive manner.

Although each facility may have its own modified list, the core DHS Standard High-alert Medication List includes:

- Heparin

- Warfarin (Coumadin)
- Thrombolytics
- Concentrated potassium
- Sodium chloride solution >0.9%
- Insulins (IV and subcutaneous)
- Narcotic/opiate analgesics (patient controlled analgesia, fentanyl continuous infusion, fentanyl transdermal patches, and methadone)
- Neuromuscular blocking agents
- Antineoplastic agents
- Magnesium sulfate (in all obstetrical areas only)

Anticoagulants (unfractionated heparin, low molecular weight heparin, and warfarin), when used at therapeutic doses, are prone to adverse events because of complex dosing, strict monitoring requirements and problems with patient compliance. Patient, family and staff education regarding the signs and symptoms of bleeding complications, plus the issues related to diet changes, medication interactions, compliance and follow-up is critical. Use the approved protocols for initiation and maintenance of anticoagulant therapy, including policies outlining the baseline and ongoing laboratory tests that are used for monitoring. Oral unit-dose products, prefilled syringes or premixed infusion bags with programmable infusion pumps reduce the possibility of anticoagulant medication administration errors.

Many medications have names that are similar to other, often unrelated, drugs. Each facility has a list of **look-alike/sound-alike drugs** and has medication safety policies that are meant to decrease the risk of inadvertent interchange of these medications. Some strategies include separate storage, special labeling, and use of TALLman labeling to highlight the differences (e.g., hyrOXYzine and HydrALAzine).

To prevent medication mix-ups during operative or other types of invasive procedures (e.g., interventional radiology, cardiac cath, etc), **label all medications and solutions**

in syringes, medicine cups, and bowls on and off the sterile field (even if there is only one). Labeling should occur at the time that the medication or solution is transferred from its original packaging to another container. (*Exception:* If a medication or solution is removed from its original container into a bowl, cup, or syringe and immediately administered and disposed of without a break in the process, labeling is not required.) Immediately discard any medications or solutions that are found unlabeled, as well as all medications and solutions on the sterile field at the end of the procedure. Use a two-person verbal and visual verification of the identity of the medication or solution when these are added to the sterile field and whenever a medication or solution is handed from one person to another during a procedure - unless the person preparing the medication or solution is the one who will be administering it. Conduct a handoff review of the medications and solutions on the sterile field when there is a change of personnel during the procedure or operation.

Reconciliation of patient medications helps to prevent the inadvertent omission or duplication of medications, drug-related allergic reactions, and food or drug interactions. Compile an accurate list of the patient's medications when the patient is admitted to a hospital or presents for an episode of care in an outpatient facility, and compare this list with drugs that are ordered for the patient. Update the list whenever the patient transfers between levels of care within the facility. At the time of discharge, transfer to another facility, or at the end of an outpatient episode of care, provide written information on the medications, as well as an explanation of the importance of managing medication information, to the patient and/or family in a format that is understandable to them. The type of medication information that needs to be collected may be separately defined by each facility for areas where medication changes are minimal or temporary, such as outpatient radiology, ambulatory surgery, emergency department, etc.

Tubing Misconnections:

Disastrous consequences can result when medications, tube feedings, contrast agents or other substances meant for intravenous, epidural, or feeding tube administration are inadvertently connected and administered through another route. This can occur because unintended tubing connections are possible. FDA regulations meant to reduce

the likelihood of epidural and tube feeding misconnections are pending. Until then, facilities are required to have processes in place to address this risk. Suggestions are:

- Always trace the port and the tubing to its insertion site to verify the correct access and route of administration
- Never attempt to force or "jury-rig" a connection that does not fit easily and securely into an access port
- For certain high-risk catheters (e.g., epidural, intrathecal, arterial), clearly label the catheter and avoid using catheters that have injection ports
- Include "line reconciliation" where the type and purpose of each catheter attached to a patient is reviewed as part of the handoff communication between caregivers at shift change and when patients are transferred between locations

Healthcare-associated Infections:

According to CDC data, at least 99,000 deaths occur each year in the U.S. related to hospital-associated infections.

Hand hygiene before and after every patient contact, using either soap and water or alcohol-based handrub, is the best way to reduce the incidence of healthcare-associated infection (HAI). Artificial fingernails represent an infection hazard and are not permitted.

See: DHS Policy #392.3 - Hand Hygiene in Health Care Settings – Joint Commission Requirements

The Joint Commission provides strategies to prevent some common healthcare-associated infections:

- To help prevent **surgical site infections** -use evidence-based practices (including timing and choice of antibiotics, method of operative site hair removal, etc);educate staff, patients and families about these practices; monitor compliance; measure processes and outcomes and provide feedback to stakeholders.

- To help prevent **infections due to multidrug-resistant organisms** (applies to hospitals) -perform periodic risk assessments and, based on the results, implement a surveillance program; use evidence-based policies/practices; utilize alert systems to identify new, readmitted and transferred patients with multidrug-resistant organisms; educate staff, patients and families about multidrug-resistant organisms; measure processes and outcomes and provide feedback to stakeholders.

- To help prevent **central line-associated bloodstream infections** (applies to hospitals) -perform periodic risk assessments; implement evidence-based policies/procedures designed to reduce the risk of central line infection; educate staff, patients and families about preventing central line infections; collect data on infection rates and provide feedback to stakeholders. Use a checklist, a standardized protocol, sterile barrier precautions, and a supply cart or kit for catheter insertion. Employ an evidence-based antiseptic skin prep; use a standardized protocol to disinfect catheter hubs and injection ports prior to accessing them; perform hand hygiene prior to catheter insertion or manipulation; do not use the femoral vein unless no other access site is available (in adults); promptly remove all catheters when no longer needed.

  See: DHS Policy #335 - Maximal Sterile Barrier Precautions

- To help prevent **ventilator-associated pneumonia** in hospitalized adults - perform hand hygiene prior to patient contact; maintain the patient in the semirecumbent position; provide regular antiseptic oral care; do a daily sedation interruption and assessment to determine readiness to wean from the ventilator; measure and monitor processes and outcomes.

- To help prevent **indwelling catheter-related urinary tract infections** in hospitalized adults - limit the use (and duration of use) of indwelling urinary catheters; utilize antiseptic insertion techniques; properly secure catheters; maintain sterility of the collecting system; measure and monitor processes and outcomes.

Patient Falls:

Patient falls are an ongoing source of potential risk for injury. Hospitals regularly assess a patient's risk for falling and the risk of harm associated with a fall. Risk factors may include altered mental status, impaired mobility, effects of medications, bladder or bowel urgency, and previous history of falling. Hospitals have implemented preventive strategies based on the risk assessment. Some strategies include - clearly identify patients who are a high risk for falling; educate patients and families about fall prevention measures; orient patients to their surroundings; remove barriers to toileting; instruct patients on the use of the call light…and respond promptly to it; avoid high bed positions; frequently assess patients (especially related to toileting needs).

Risk for Suicide:

For patients admitted to a general acute care hospital who are being treated for emotional or behavioral disorders - assess the risk of suicide; address their immediate safety needs in this regard; at the time of discharge, provide the patient and/or family with a list of community resources such as a crisis hotline number. Educate staff members about how to identify and respond to patients exhibiting risk factors for suicide.

Prompt Response to Patient Deterioration:

Know how to recognize the early warning signs of a patient's deteriorating clinical condition and know how to seek additional assistance when there are concerns about a patient's condition. Empower the patient and family to call for assistance under similar circumstances.

Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery:

There are three essential steps to help prevent doing wrong site, wrong procedure, and wrong person procedures:

- Pre-procedure verification: With the patient involved as much as possible, ensure that the consent, the medical record, and the patient's understanding of the intended procedure and site are in agreement. Also, using a standardized list, ensure that all needed documents, test results, required blood products, implants, devices, and any special equipment are available prior to the procedure.

- Site marking: Site marking is required when there is the possibility for wrong-site procedures, such as left/right laterality, multiple structures such as fingers or toes, multiple lesions, and spinal levels. Involving the patient as much as possible, mark the site on the patient's skin at or near the incision site with a marker that will not be washed off with the skin prep, and ensure that the mark will be visible after draping. The method of marking is unambiguous (e.g., surgeon's initials) and used consistently throughout the facility. Site marking is done by a physician who is ultimately accountable for the procedure and who will be present when the procedure is performed. Under certain circumstances, a resident who is involved with the procedure may do the site marking. Site marking is also done prior to peripheral nerve block anesthesia. Take special care to ensure that site marks are visible if change in the patient's position is required. If site marking is indicated but anatomically impractical, contraindicated (e.g., premature infants) or refused by the patient, utilize the facility's written alternative method that is in place for this circumstance.

- Time out: A "time out" occurs immediately before starting an invasive procedure, making a skin incision, and prior to neuraxial (spinal/epidural) or peripheral nerve block anesthesia. The time out is standardized by the facility, is initiated by a designated member of the team, and involves all members of the team. During the time out, all agree (at a minimum) on the correct patient, correct site, and correct procedure to be done. Document the time out in the medical record.

The Universal Protocol applies not only in the operating room, but anywhere invasive procedures are done…such as interventional radiology, cath lab, GI lab, emergency department, and the bedside.

Other Issues Affecting Surgical and Procedural Safety:

A **fire in the operating room** can injure patients and staff. A surgical fire requires three elements: fuel (often alcohol-containing skin prep), oxygen (typical of the high-oxygen environment around the head and neck – especially with the tenting effect of surgical drapes), and an ignition source (such as electrocautery or laser). Steps to help prevent a surgical fire are:

- Be aware of the high-oxygen environment, especially under surgical drapes, and particularly with head and neck surgery
- When flammable skin prep solutions are used, make sure that they are completely dry and there is no "pooling" of solution under or around the patient
- Place electrosurgical devices in a holster or other safe location off of the patient when not in use
- Place lasers in standby mode when not in use
- Be knowledgeable about the location and use of fire equipment, including shutting off of flammable gases and electrical units

Retained surgical materials can cause patient harm and can lead to litigation. Count sponges, needles, and instruments before, during, and at the conclusion of surgeries, and promptly resolve discrepancies – using x-ray examinations if needed. Do not place non-radiopaque sponges or towels in the operative wound, and do not use broken instruments or those whose functional integrity is in question. Accomplish a careful body cavity or wound check prior to closure.

Needlestick injuries are common hazards for healthcare workers in the operating room, in the clinic, during interventional procedures, and at the bedside. Scalpel injuries occur mainly in the operating room. Exposure to transmissible infectious diseases can be minimized by:

- Not recapping used needles
- Using sharps containers for disposal of all single-use sharps
- Using needleless systems where appropriate

- Avoiding hand-to-hand passage of scalpels (e.g., pass scalpel in a small basin)

Pressure Ulcers:

A pressure ulcer, sometimes called a decubitus ulcer, is a common, often preventable, hospital-acquired adverse event. Tissue is damaged as a result of pressure over time – and usually occurs where a bony prominence overlies a hard surface. The dead tissue often becomes infected, leading to further damage and possible sepsis. The clinical signs of pressure ulcer will progress from intact discolored skin to blistering, superficial ulcer, full thickness skin loss with visible subcutaneous fat, and eventually down to underlying bone, tendon or muscle. Healing is slow and sometimes requires complex plastic surgical procedures to achieve skin coverage and repair the damage. Some tips to prevent pressure ulcers are:

- Perform an assessment for the risk of pressure ulcer at the time of admission
- Address risk factors such as poor nutrition, immobility, incontinence, extremes of under- and overweight body habitus
- Perform frequent skin assessments during the hospital stay
- Provide frequent changes in patient position, as permitted by the patient's medical condition
- Use skin protective devices such as pillows, wedges, specialized beds, and lifting devices such as a trapeze

Bed Entrapment and Physical Restraints:

Patient harm, particularly death due to strangulation, can result from the use of bedrails and other restraints that restrict freedom of movement. The spaces between the bedrail bars, between the bars and the mattress, and between the bars and the headboard and footboard are all potential sites where confused patients can get trapped. Newly designed beds have bedrails that reduce the risk of entrapment.

Similarly, physical restraints that partially immobilize a patient can result in the strangulation of a struggling, confused patient. Use these devices solely for the protection of the patient, and weigh the benefit for an individual patient against the risk of harm. Be familiar with each hospital's strict policies and procedures regarding the indications for their use, and the need for specific physician orders, assessments, reassessments, and frequent observations. Maintain an unobstructed airway at all times. Use the least restrictive devices for the shortest period of time, consistent with the patient's needs, and consider alternatives to physical restraints such as medications and sitters.

MRI Safety:

The powerful magnetic field associated with an MRI machine can result in patient harm in several ways. The most common injuries are burns during exams when the magnetic force heats iron-containing wires and leads, monitoring cables, medication delivery patches, tattoos, etc. Infusion pumps, monitors, pacemakers and defibrillators are at risk for erratic function, and malfunction of external or implantable devices that are affected by the magnetic field can occur. Patients and staff members can be seriously injured by

the missile effect caused when iron-containing objects such as oxygen tanks, wheelchairs, bedrails, infusion pumps, pens or other objects fly into the magnet at high velocity.

Understand that the MRI magnet is always "on," even when there is no exam in progress.

Do not place iron-containing objects in proximity to the MRI machine at any time. Essential precautions to prevent MRI-related injuries include:

- Restrict access to MRI sites by creating zones where only appropriately screened individuals can enter
- Ensure that only personnel who are knowledgeable about the MRI environment have access to the MRI suite at all times
- Use only non-ferromagnetic equipment, such as fire extinguishers, oxygen cylinders, physiologic monitors, etc

- Use trained personnel to screen patients about metal objects they may have on them
- Ensure that the patient's medical history elicits information about implants such as pacemakers, defibrillators, drug infusion devices, aneurysm clips, cochlear implants, etc
- Take precautions to avoid burns, such as ensuring that patient leads or other wires are not looped, and placing ice packs on tattoos
- Provide patients with ear protection (because of the loud noises associated with MRI exams)
- Never run a cardiopulmonary arrest code or resuscitation within the MRI magnet room

APPENDIX I

2012 JOINT COMMISSION NATIONAL PATIENT SAFETY GOALS

For Hospitals

This is the current list of Joint Commission National Patient Safety Goals for hospitals. Some previous safety goals have now been reclassified as Joint Commission standards. For detailed requirements of the elements of performance related to these safety goals and patient safety-related standards, see the *Joint Commission Comprehensive Accreditation Manual for Hospitals*.

Goal 1 – *Improve the accuracy of patient identification*

NPSG.01.01.01 – Use at least two patient identifiers when providing care, treatment and services

NPSG.01.03.01 – Eliminate transfusion errors related to patient identification

Goal 2 – *Improve the effectiveness of communication among caregivers*

NPSG.02.03.01 – Report critical results of tests and diagnostic procedures on a timely basis

Goal 3 – *Improve the safety of using medications*

NPSG.03.04.01 – Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings

NPSG.03.05.01 – Reduce the likelihood of patient harm associated with the use of anticoagulant therapy

NPSG.03.06.01 – Maintain and communicate accurate patient medication information

Goal 7 – *Reduce the risk of healthcare-associated infections*

NPSG.07.01.01 – Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines

NPSG.07.03.01 – Implement evidence-based practices to prevent healthcare-associated infections due to multidrug-resistant organisms in acute care hospitals

NPSG.07.04.01 – Implement evidence-based practices to prevent central line-associated bloodstream infections

NPSG.07.05.01 – Implement evidence-based practices for preventing surgical site infections

NPSG.07.06.01 – Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections

Goal 15 – *The hospital identifies safety risks inherent in its patient population*

NPSG.15.01.01 – Identify patients at risk for suicide

Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

UP.01.01.01 – Conduct a preprocedure verification process

UP.01.02.01 – Mark the procedure site

UP.01.03.01 – A time-out is performed before the procedure

APPENDIX II

2012 JOINT COMMISSION NATIONAL PATIENT SAFETY GOALS

For Ambulatory Care

This is the current list of Joint Commission National Patient Safety Goals for ambulatory care. Some previous safety goals have now been reclassified as Joint Commission standards. For detailed requirements of the elements of performance related to these safety goals and patient safety-related standards, see the *Joint Commission Comprehensive Accreditation Manual for Ambulatory Care*.

Goal 1 – *Improve the accuracy of patient identification*

NPSG.01.01.01 – Use at least two patient identifiers when providing care, treatment and services

NPSG.01.03.01 – Eliminate transfusion errors related to patient identification

Goal 3 – *Improve the safety of using medications*

NPSG.03.04.01 – Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings

NPSG.03.05.01 – Reduce the likelihood of patient harm associated with the use of anticoagulant therapy

NPSG.03.06.01 – Maintain and communicate accurate patient medication information

Goal 7 – *Reduce the risk of healthcare-associated infections*

NPSG.07.01.01 – Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines

NPSG.07.05.01 – Implement evidence-based practices for preventing surgical site infections

Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

UP.01.01.01 – Conduct a preprocedure verification process

UP.01.02.01 – Mark the procedure site

UP.01.03.01 – A time-out is performed before the procedure

APPENDIX III

CDPH-REPORTABLE ADVERSE EVENTS

The California Department of Public Health (CDPH) has adopted the following list of 28 adverse events that, should they occur in a general acute care hospital, require prompt reporting to the state.

These adverse events are felt to be unambiguous, serious, usually preventable, important for public credibility/accountability, and may be indicative of a problem in the hospital's safety systems.

We are required to report any of these adverse events (a) within five days after it has been detected or (b) within 24 hours after it has been detected if it is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel or visitors.

Surgical Events

- Surgery on the wrong body part
- Surgery on the wrong patient
- The wrong surgical procedure performed on the patient
- Unintentional retention of a foreign object
- Unexpected death within 24 hours of anesthesia

Product or Device Events

- Patient death or serious disability associated with a contaminated drug, device or biologic
- Patient death or serious disability associated with use or function of a device in which the device is used other than as intended
- Patient death or serious disability associated with intravascular air embolism

Patient Protection Events

- Infant discharged to the wrong person

- Patient death or serious disability associated with patient disappearance for more than four hours
- Patient suicide or attempted suicide resulting in serious disability due to actions after admission to the facility

Care Management Events

- Patient death or serious disability associated with a medication error
- Patient death or serious disability associated with a hemolytic transfusion reaction due to administration of ABO-incompatible blood or blood products
- Maternal death or serious disability associated with labor and delivery in a low-risk pregnancy (including events that occur within 42 days postdelivery)
- Patient death or serious disability directly related to hypoglycemia
- Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life
- Stage 3 or 4 ulcer, acquired after admission to the facility
- Patient death or serious disability due to spinal manipulative therapy

Environmental Events

- Patient death or serious disability associated with an electric shock
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance
- Patient death or serious disability associated with a burn
- Patient death associated with a fall while being cared for in the facility
- Patient death or serious disability associated with the use of restraints or bedrails

Criminal Events

- Any instance of care ordered or provided by someone impersonating a physician, nurse, pharmacist, or other licensed provider
- Abduction of a patient of any age
- Sexual assault on a patient
- Death or significant injury of a patient or staff member from a physical assault

An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel or visitor

See Section 1279.1 of the California Health and Safety Code for further details.

ESSENTIAL ELEMENTS OF PATIENT SAFETY

Questions

1. **Who is responsible for reporting a patient safety occurrence?**
   A. Front-line caregivers
   B. Managers
   C. Facility executives
   D. All of the above

2. **A patient's bed or room number can be used as a reliable source of identification**
   A. True
   B. False

3. **Which abbreviation is acceptable for use in the medical record when referring to a** medication?
   A. U
   B. QD
   C. MgSO4
   D. None of the above

4. **Special methods of handling high-alert medications include**
   A. Active, independent double-check prior to administration
   B. Reducing the number of drug concentrations available
   C. Special protocols to guide their use
   D. All of the above

5. **During an operative or invasive procedure, a medication or solution in a syringe, medicine cup, or bowl does <u>not</u> need to be labeled if it is the only medication or solution on the field**
   A. True
   B. False

6. **Hand hygiene using soap and water or alcohol-based handrub is the best way to reduce the incidence of healthcare-associated infections**
   A. True
   B. False

7. **Proven strategies to help prevent patient falls include all of the following except**
   A. Removal of barriers to toileting
   B. Instruction in use of call light…and prompt response to it
   C. Reminding patients to be careful and not to fall
   D. Orientation of patients to their surroundings

8. **A "time out" prior to an operative or invasive procedure has all the following characteristics except**
   A. It is initiated by a designated member of the team
   B. It involves all members of the team
   C. It involves, at a minimum, confirming the correct patient, correct site, and correct operation or procedure
   D. It is performed only at the discretion of the surgeon or physician performing the procedure

9. **Risk factors for pressure (i.e. decubitus) ulcers include all of the following except**
   A. Poor nutrition
   B. Early ambulation
   C. Incontinence
   D. Extreme over- or under-weight body habitus

10. **Precautions to avoid patient or staff injury from the "missile effect" of flying iron-containing objects being drawn into the powerful MRI magnet at high velocity must be in effect at all times, even if there is no exam in progress, because the MRI magnet is always "on"**
    A. True
    B. False

_____
Name

_____
Date