

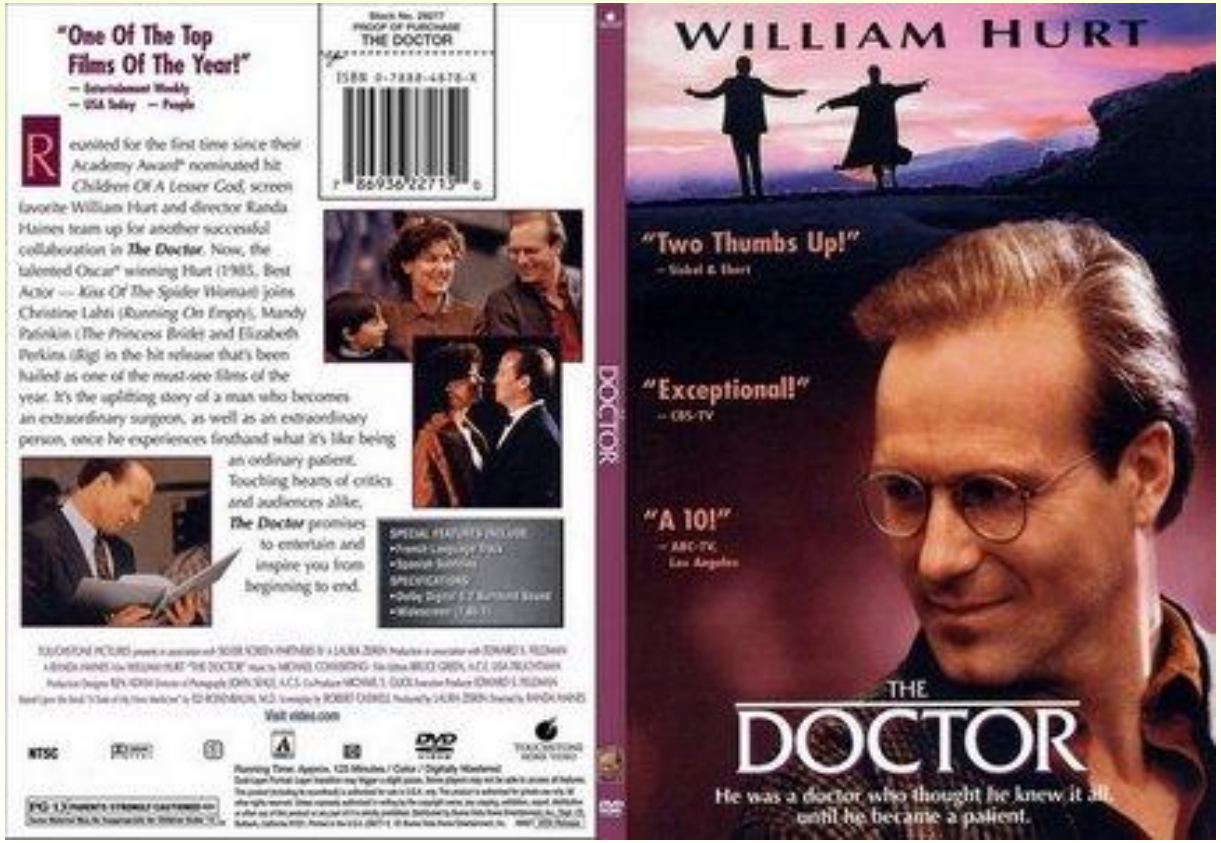
CPHQ Preliminary Course

Patient Safety

Ahmed Yahia, MD, MPH, CPHQ

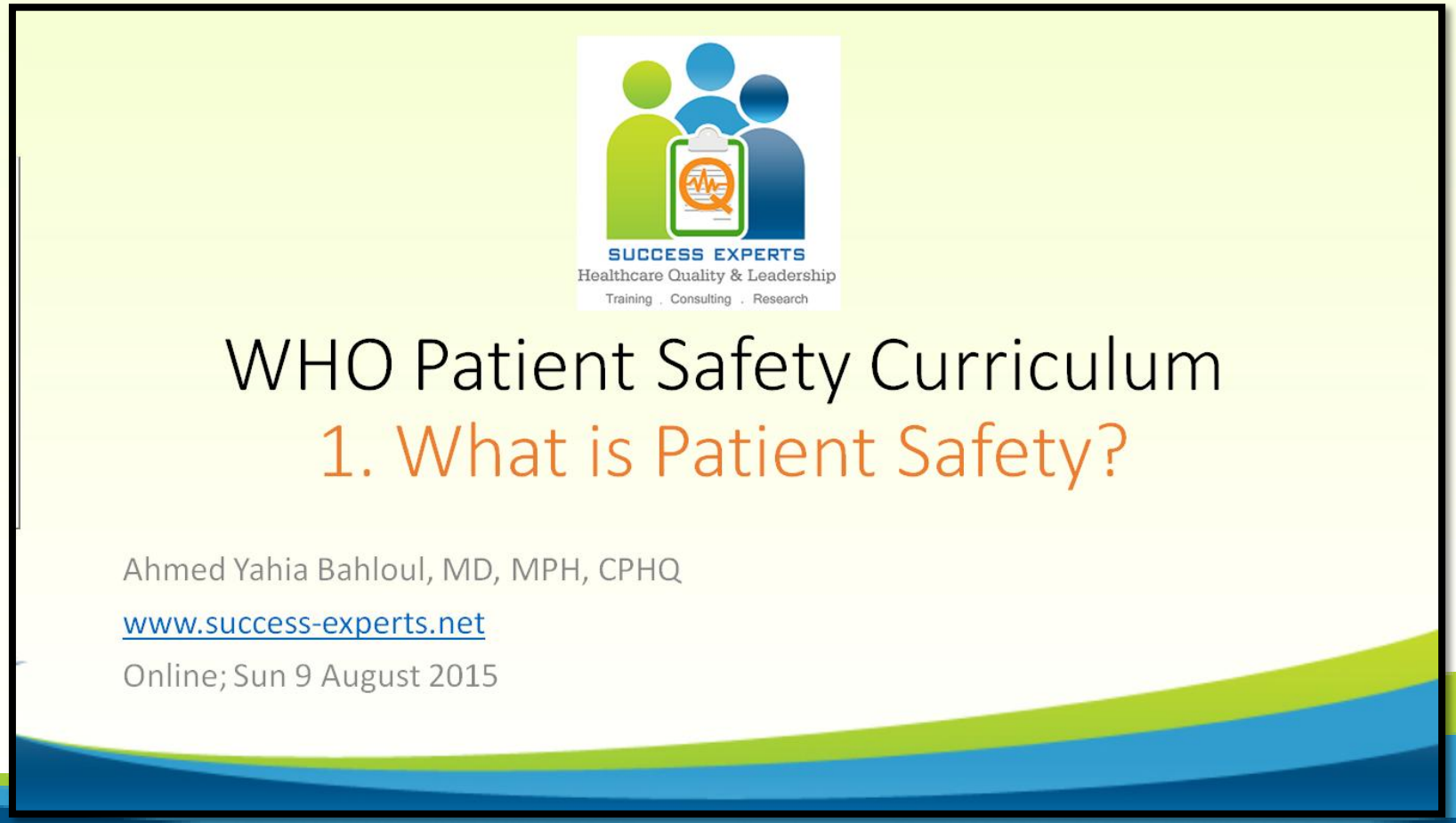
www.success-experts.net

The Doctor, 1991

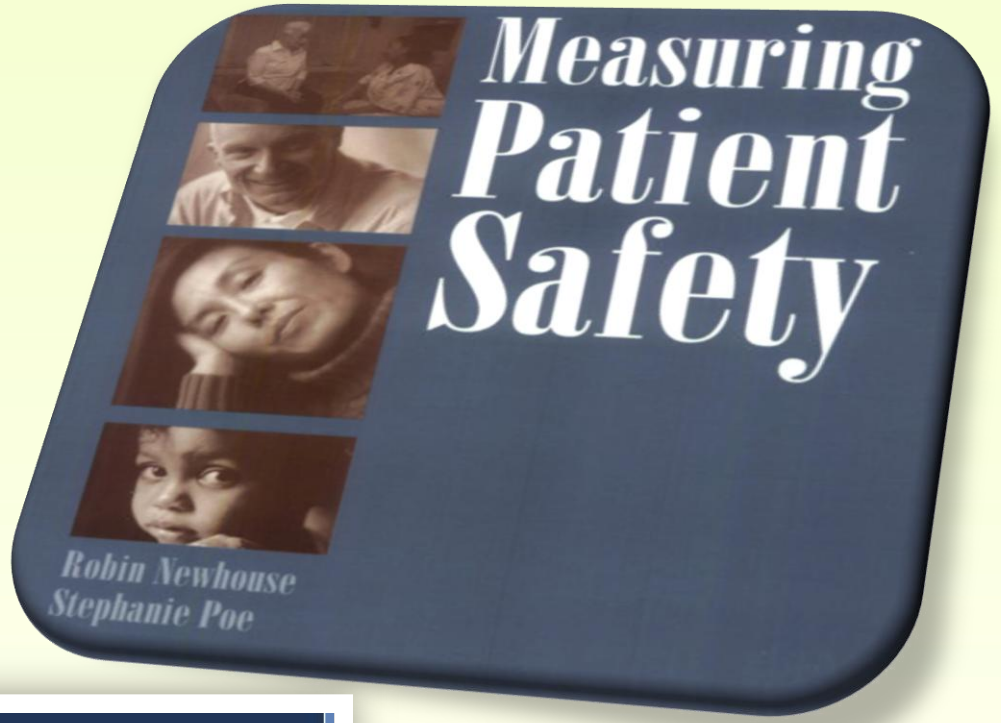


WHO Patient Safety Curriculum: Session 1

- https://www.youtube.com/watch?v=K7WVFhQe1Yw



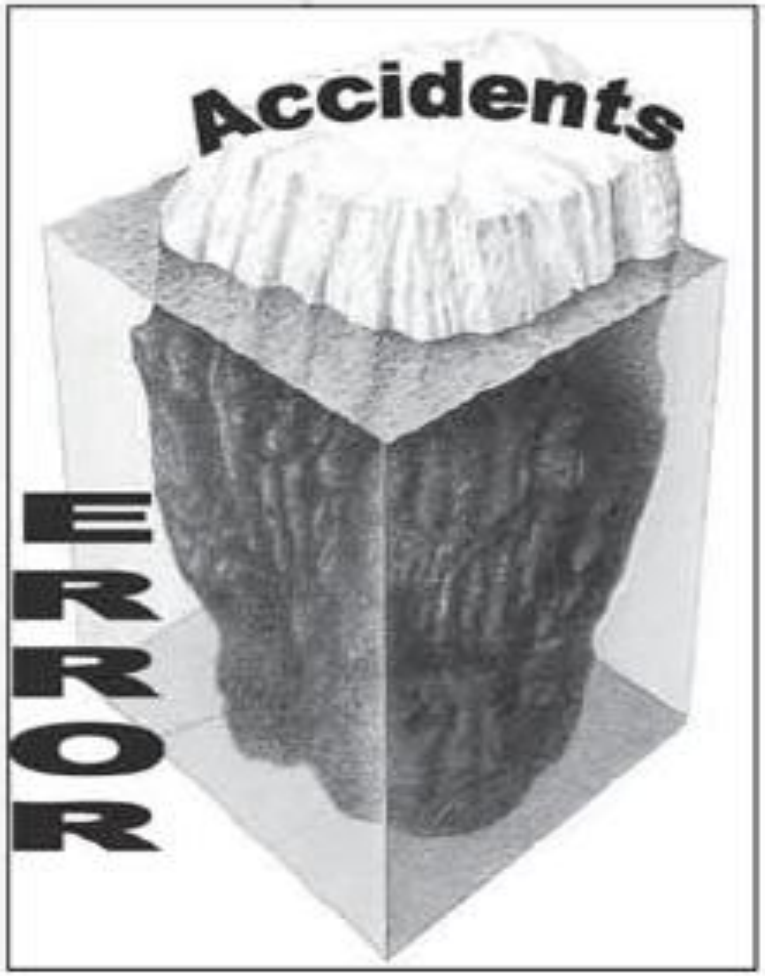

Q SOLUTIONS
Essential Resources for the Healthcare Quality Professional
SECOND EDITION
NAHQ


Measuring Patient Safety
Robin Newhouse
Stephanie Poe


QS JB QUALITY SOLUTIONS, INC.
HOME
ABOUT THE AUTHOR
REVIEWS AND FEEDBACK
CONTACT US
PURCHASE
THE HANDBOOK
WORKSHOP
WORKSHOP AUDIO
About the Author
Author
Janet Brown, BA, BSN, RN, CPHQ, FNAHQ, has been active in the healthcare quality field since 1978 as an administrative director, consultant, and nationally known educator. She is President/CEO of JB Quality Solutions, Inc., and has been a business owner since 1984. She is passionate about the value of the quality professional in healthcare and the need to validate and promote that expertise and has spent the last 23 years developing and providing resources to that end.
She has worked with more than 50 healthcare organizations, including hospitals, ambulatory care centers and surgical centers, mental health facilities, review agencies, managed care organizations, and healthcare delivery systems in quality management/ improvement, utilization and case management clinical risk management, information management, strategic planning, and systems development. She helped prepare for, and participated in, more than 35 accreditation and/or licensure surveys.

- First, Do No Harm. Hippocratic Maxim.
- We cannot improve what we cannot measure.
- Improving care comes from changing the system.. Not individuals.

Figure 4.3 Accidents Are Only the Tip of the Iceberg



- 44,000 – 98,000 preventable deaths occur every year in US hospitals (IOM estimation 1999)



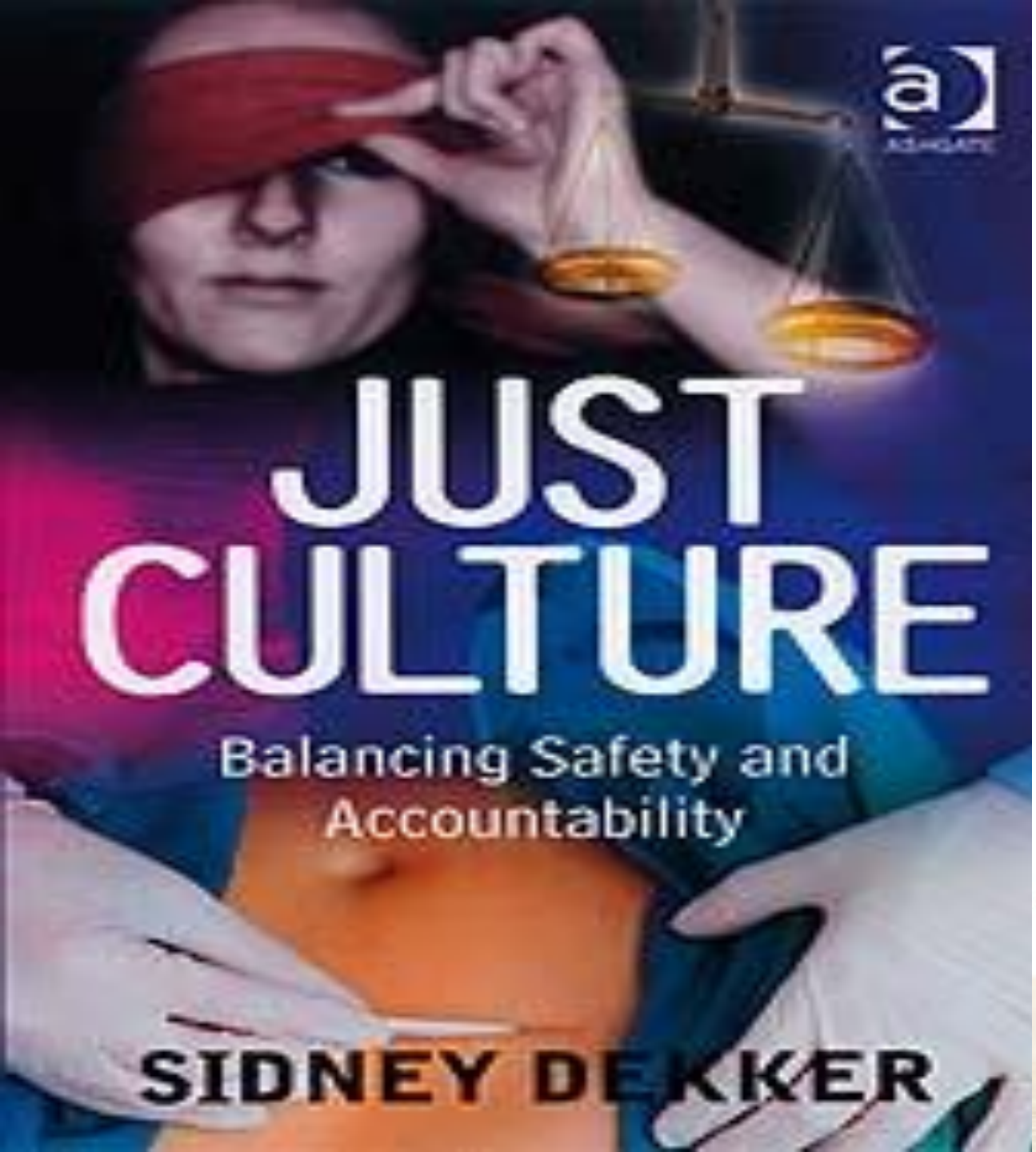

Equity
Barrier-free
Timeliness
Ready and waiting…for you
Effectiveness
Getting it right
Efficiency
Getting it right the first time…Priceless
Patient-Centeredness
Nothing about me without me
Safety
You are safe at SJMHS

Leadership and culture:

Mistake-proofing (Poka-yoke):

- The use of process or design features to prevent errors or the negative impact of errors.

- Leaders to ask “what happened” instead of “ who made the errors”. The culture here will begin to change.


JUST
CULTURE
Balancing Safety and
Accountability
SIDNEY DEKKER



Fair and just culture (non-punitive and accountable):

- Every one is aware that medical errors are inevitable.
- All events and near misses to be reported. It can make the system safer.
- Competent professionals make mistakes and develop unhealthy norms (shortcuts or routine rule violations), but it has zero tolerance for reckless behavior.

- **3 basics:**

1. It doesn't reduce the personal accountability and discipline. It emphasizes the learning from the errors and near misses to reduce errors in the future.
2. The greatest error not to report a mistake. Thereby prevent learning.
3. All in the organization to serve as safety advocates. Both providers and consumers will feel safe and supported when they report medical errors, near misses and voice concerns about patient safety.

Learning Organization (Senge's concept):

- "Where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, Where collective aspiration is set free, and where people are continually learning to see the whole together".

- A learning healthcare system "is designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; and to ensure innovation, Quality, Safety, and value in healthcare" IOM Roundtable on EBM (ROEBM 2007)

An Introduction to Just Culture

"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."

Don Norman
Author, the Design of Everyday Things

An Introduction to Just Culture

The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement





Accountability for Our Behaviors

Human Error	At-Risk Behavior	Reckless Behavior
Inadvertent action: slip, lapse, mistake	*A choice: risk not recognized or believed justified*	*Conscious disregard of unreasonable risk*
Manage through changes in:	Manage through:	Manage through:
Processes Procedures Training Design	emoving incentives for At-Risk Behaviors reating incentives for healthy behaviors ncreasing situational awareness	Remedial action Punitive action
Console	**Coach**	**Punish**

Just culture

≠ Blame Free Policy

Table 1 Characteristics of Successful Reporting Systems (7)

Non-punitive	Reporters are free from fear of retaliation against themselves or punishment of others as a result of reporting.
Confidential	The identities of the patient, reporter, and institution are never revealed.
Independent	The reporting system is independent of any authority with power to punish the reporter or the organization.
Expert analysis	Reports are evaluated by experts who understand the clinical circumstances and are trained to recognize underlying systems causes.
Timely	Reports are analysed promptly and recommendations are rapidly disseminated to those who need to know, especially when serious hazards are identified.
Systems-oriented	Recommendations focus on changes in systems, processes, or products, rather than being targeted at individual performance.
Responsive	The agency that receives reports is capable of disseminating recommendations. Participating organizations commit to implementing recommendations whenever possible.

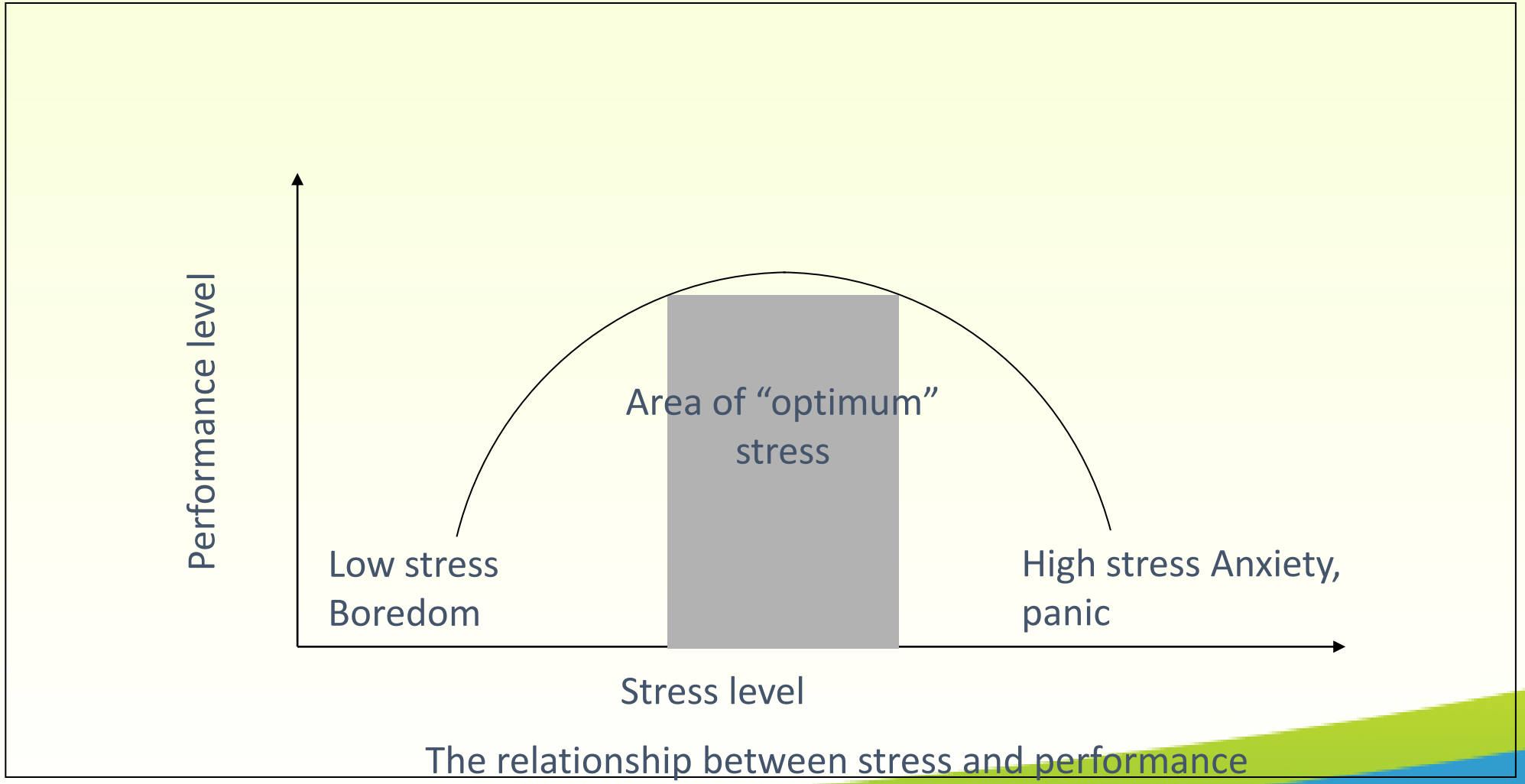
Human Factor Engineering

- Error proofing/Reduction technique
- It is the study of human interactions with others, equipments, technology, surrounding environment. It discusses the human ability and limitations.
- Human factors to be considered in healthcare (NPSF):
- 1- sleep deprivation
- 2- Interruptions

Individual factors that predispose to error (WHO)

- limited memory capacity
- further reduced by:
  - fatigue
  - stress
  - hunger
  - illness
  - language or cultural factors
  - hazardous attitudes

Stress and performance



The relationship between stress and performance

Yerkes, R. M., & Dodson, J. D. (1908) The relation of strength of stimulus to rapidity of habit-formation. *Journal of Comparative Neurology and Psychology, 18*, 459-482

RED RULES

- Are those must be followed to the letter and if there is a condition or situation that poses risk, red rules “stop the line”. AHRQ patient safety network 2008



Examples of **Red rules in healthcare**

- **Pt identification using at least 2 identifiers before any step of care.**
- **Reconciliation of sponge count**
- **Time out before an invasive procedure**

The patient safety program should be aligned with the Mission, Vision, Core Values and Goals of the Organization.

IHI 6 recommendations for integration of Quality and Safety in strategic planning to improve Quality and reduce harm:

1) Setting aims: to reduce harm this year
2) Getting data and hearing stories: as a first agenda item at every board meeting.
3) Establishing and monitoring system-level measures: Communicate them to all with transparency.
4) Changing the environment, policies and culture: respectful, fair and just for all encountered any pain and loss as a result of avoidable harm (patients, Families, Staff).
5) Learning: starting with the board.
6) Establishing executive accountability.

- Third-party payer:

nonpayment for certain conditions that could have been reasonably prevented (e.g.: pressure ulcer) and serious preventable events (e.g.: leaving a sponge in patient during surgery)

Quality and Safety can bring benefits to a financially stable and growing healthcare organization.

Priority PATIENT SAFETY topics:

- Sentinel event
- Patient safety goals
- Hospital acquired infection
- Medication safety
- Nurse-sensitive safety measures



Sentinel Event



Sentinel event

- an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

- The phrase, ‘or risk thereof’ includes any process variation for which a recurrence carries a significant chance of a serious adverse outcome.”

- Such events are called "sentinel" because they signal the need for immediate investigation and response.

Sentinel event

- The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel event

Sentinel event

= Never event

= unexpected event

= Reportable Serious Event

Sentinel events

- Adverse drug events
- Improper blood transfusions
- Surgical injuries
- Wrong-site surgery
- Patient suicides
- Restraint-related injuries or death
- Patient falls
- Patient burns
- Infant abduction
- Mistaken patient identities

Sentinel Event

Sentinel Event Alert

- Sentinel Event Alert, Issue 46: A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department
- Sentinel Event Alert, Issue 45: Preventing violence in the health care setting
- Sentinel Event Alert, Issue 44: Preventing Maternal Death

View More

Statistics

- New! Sentinel Event Data Summary
- New! Sentinel Event Data - General Information
- New! Sentinel Event Trends

In support of its mission to improve the quality of health care provided to the public, The Joint Commission includes the review of organizations' activities in response to sentinel events in its accreditation process, including all full accreditation surveys and random unannounced surveys.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. For more information see Sentinel Event Policy and Procedures.

FAQs

Radiation Overdose

- The parameters that specify when these events are reviewable seem very high; in fact, much higher than are specified by the relevant practice guidelines and regulations. Why is that?
- Are we now required to keep track of the cumulative fluoroscopy dose for all patients having fluoroscopy exams and report when they have a cumulative dose of 1500 rads?

Retained Foreign Object After Surgery

- When, exactly, is "after surgery"?
- Why was this particular point in the process selected as the definition of "after surgery?
- Sometimes a needle or screw will break leaving a fragment behind. Is this a reviewable sentinel event?

View More

Podcasts

Sentinel Event Alert, Issue 41: Preventing errors relating to commonly used anticoagulants

By Joint Commission

Sentinel Event Alert, Issue 40: Behaviors that undermine a culture of safety

By Joint Commission

View More

Forms and Tools

- Affirmation Statement
- Alternatives for Sharing Sentinel Event-Related Information with The Joint Commission
- Framework for Conducting a Root Cause Analysis and Action Plan
- Self Report Form

CMS& NQF list of Sentinel Events

- CMS proposes to withhold payment to hospitals if any of these events occurs in an acute care facility.

- It is called Never Events, Serious Reportable Adverse Events, Unexpected Events, Sentinel Events.

Which of the following is NOT considered as a SENTINEL EVENT:

A. Patient fall in the ward.

B. Suicide threat by a patient in psychiatric ward.

C. Blood transfusion reaction.

D. Wrong site surgery.

Patient Safety Goals





ACCREDITATION
CANADA

Better Quality. Better Health.

Required Organizational Practices

Handbook 2015

CHART OF REQUIRED ORGANIZATIONAL PRACTICES

SAFETY CULTURE	▪ Accountability for quality ★ ▪ Adverse events disclosure ▪ Adverse events reporting ▪ Client safety quarterly reports ▪ Client safety-related prospective analysis
COMMUNICATION	▪ Client and family role in safety ▪ Dangerous abbreviations ▪ Information transfer ▪ Medication reconciliation as a strategic priority ▪ Medication reconciliation at care transitions ▪ Safe surgery checklist ▪ Two client identifiers
MEDICATION USE	▪ Antimicrobial stewardship ▪ Concentrated electrolytes ✣ ▪ Heparin safety ✣ ▪ High-alert medications ✣ ▪ Infusion pumps training ▪ Narcotics safety ✣
WORKLIFE/WORKFORCE	▪ Client flow ★ ▪ Client safety: education and training ▪ Client safety plan ▪ Preventive maintenance program ▪ Workplace violence prevention
INFECTION CONTROL	▪ Hand-hygiene compliance ♦ ▪ Hand-hygiene education and training ♦ ▪ Infection rates ♦ ▪ Pneumococcal vaccine ▪ Reprocessing
RISK ASSESSMENT	▪ Falls prevention strategy ▪ Home safety risk assessment ▪ Pressure ulcer prevention ▪ Skin and wound care ★ ▪ Suicide prevention ▪ Venous thromboembolism (VTE) prophylaxis

CBAHI

المركز السعودي لاعتماد المنشآت الصحية
Saudi Central Board for Accreditation of Healthcare Institutions



المعايير الوطنية
للمستشفيات

NATIONAL HOSPITAL STANDARDS

THIRD EDITION 2015

SAUDI CENTRAL BOARD FOR ACCREDITATION OF HEALTHCARE INSTITUTIONS

CBAHI

Effective
1 January 2016

There are (16) Essential Safety Requirements distributed in the different chapters of this manual as follows:

HR.5	The hospital has a process for proper credentialing of staff members licensed to provide patient care.
MS.7	Medical staff members have current delineated clinical privileges.
PC.25	Policies and procedures guide the handling, use, and administration of blood and blood products.
PC.26	Patients at risk for developing venous thromboembolism are identified and managed.
QM.17	The hospital has a process to ensure correct identification of patients.
QM.18	The hospital has a process to prevent wrong patient, wrong site, and wrong surgery/procedure.
AN.2	Anesthesia staff members have the appropriate qualifications.
AN.15	Qualified staff perform moderate and deep sedation/analgesia.
IPC.4	There is a designated multidisciplinary committee that provides oversight of the infection prevention and control program.
IPC.15	Facility design and available supplies support isolation practices.
MM.5	The hospital has a system for the safety of high-alert medications.
MM.6	The hospital has a system for the safety of look-alike and sound-alike (LASA) medications.
MM.41	The hospital has a process for monitoring, identifying, and reporting significant medication errors, including near misses, hazardous conditions, and at-risk behaviors that have the potential to cause patient harm.
LB.51	The blood bank develops a process to prevent disease transmission by blood/platelet transfusion.
FMS.9	The hospital ensures that all its occupants are safe from radiation hazards.
FMS.32	The hospital ensures proper maintenance of the medical gas system.


Effective 1 April 2014
Joint Commission International
Joint Commission International Accreditation Standards for Hospitals
Including Standards for Academic Medical Center Hospitals
5th Edition

IPSGs





6 IPSGs are for all staff not medical staff only

JCI International Patient Safety Goals

1. Identify patients correctly
2. Improve effective communication
3. Improve the safety of high-alert medications
4. Ensure right-site, right-patient, right-procedure surgery
5. Reduce the risk of health care-associated infections
6. Reduce the risk of patient harm from falls

Joint Commission International

31

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Changes to the IPSG Chapter

Standard	Change	Explanation
IPSG.1	Requirement change	Eliminates two MEs for overall clarity of the requirements
IPSG.2	Requirement change	Expands intent to include two additional standards for verbal/telephone communications: reporting of critical results of diagnostic tests (IPSG.2.1; formerly Standard AOP.5.3.1, 4th edition) and handovers of patient care (IPSG.2.2, new standard); emphasizes the need for more focused compliance on three distinct communication-related issues
IPSG.2.1	Requirement change	Moves requirement from AOP.5.3.1 (4th edition) to highlight reporting of critical results of diagnostic tests as an important communication issue
IPSG.2.2	New standard	Introduces a new requirement for effective handovers of patient care within the hospital
IPSG.3 and IPSG.3.1	Requirement change	Divides IPSG.3 (4th edition) into two standards to clarify expectations for high-alert medications (including medications involved in a high percentage of errors/sentinel events and look-alike/sound-alike medications; IPSG.3) and concentrated electrolytes (IPSG.3.1), emphasizing more focused compliance on two distinct medication-related issues
IPSG.4 and IPSG.4.1	Requirement change	Divides IPSG.4 (4th edition) into two standards to clarify the purpose and content of the preoperative verification process and the approach for the time-out procedure
IPSG.5	Requirement change	Incorporates elements of PCI.9 (4th edition), thereby consolidating hand-hygiene requirements into one standard
IPSG.6	Requirement change	Clarifies the need to address fall risk assessment and reassessment in both inpatients and outpatients

IPSG 1



Pt identification

Key element: at least 2 identifiers NOT including the room/bed No. or pt location.

IPSG 2

Improve communication

Key elements: Read Back – critical test/result (panic values) - Telephone Orders


World Health Organization
Patient Safety
A World Alliance for Safer Health Care
WHO Patient Safety Research
Better Knowledge for Safer Ca

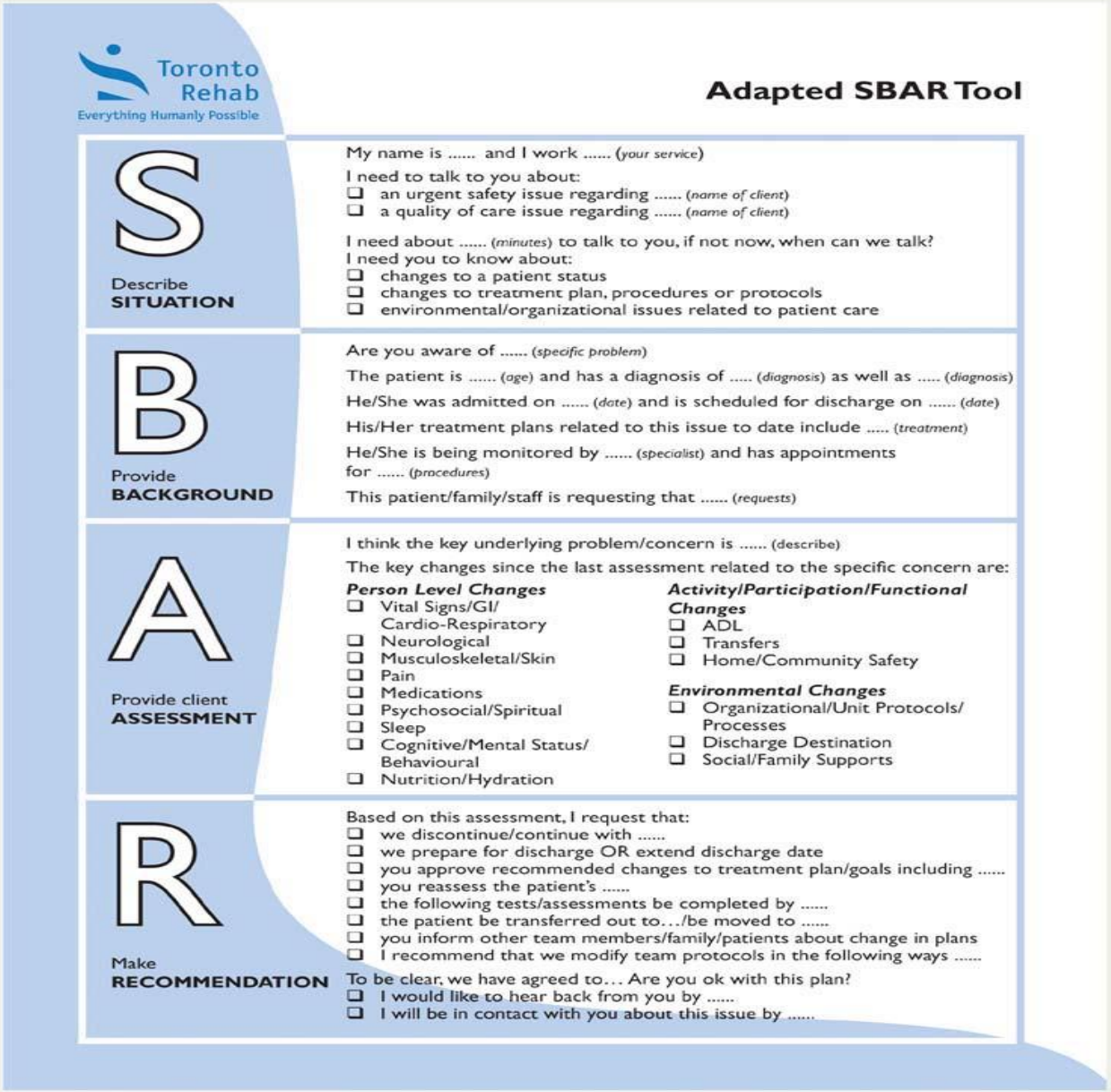
Table 1. Six ranked research priorities

	Developing countries	Countries in transition	Developed countries
	Strong emphasis on applied and evaluative research leading to the development of local cost-effective solutions		
1.	Counterfeit & substandard drugs	Inadequate competencies & skills	Lack of communication & coordination (including coordination across organizations, discontinuity & handovers)
2.	Inadequate competencies & skills	Lack of appropriate knowledge & transfer	Latent organizational failures
3.	Maternal & newborn care	Lack of communication & coordination (including coordination across organizations, discontinuity & handovers)	Poor safety culture & blame-oriented processes
4.	Health care-associated infections	Health care-associated infections	Inadequate safety indicators
5.	Unsafe injection practices	Maternal and newborn care	Adverse drug events due to drugs & medication errors
6.	Unsafe blood practices	Adverse events due to drugs & medication errors	Care of the frail & elderly

Write down, read back, confirm

For Verbal orders (ER/ICU/OR): read back, confirm, Write down

Figure 1. The adapted SBAR tool



Toronto Rehab
Everything Humanly Possible

Adapted SBAR Tool

S — Describe **SITUATION**

My name is ..... and I work ..... (*your service*)

I need to talk to you about:
- ❑ an urgent safety issue regarding ..... (*name of client*)
- ❑ a quality of care issue regarding ..... (*name of client*)

I need about ..... (*minutes*) to talk to you, if not now, when can we talk?

I need you to know about:
- ❑ changes to a patient status
- ❑ changes to treatment plan, procedures or protocols
- ❑ environmental/organizational issues related to patient care

B — Provide **BACKGROUND**

Are you aware of ..... (*specific problem*)

The patient is ..... (*age*) and has a diagnosis of ..... (*diagnosis*) as well as ..... (*diagnosis*)

He/She was admitted on ..... (*date*) and is scheduled for discharge on ..... (*date*)

His/Her treatment plans related to this issue to date include ..... (*treatment*)

He/She is being monitored by ..... (*specialist*) and has appointments for ..... (*procedures*)

This patient/family/staff is requesting that ..... (*requests*)

A — Provide client **ASSESSMENT**

I think the key underlying problem/concern is ..... (describe)

The key changes since the last assessment related to the specific concern are:

Person Level Changes
- ❑ Vital Signs/GI/ Cardio-Respiratory
- ❑ Neurological
- ❑ Musculoskeletal/Skin
- ❑ Pain
- ❑ Medications
- ❑ Psychosocial/Spiritual
- ❑ Sleep
- ❑ Cognitive/Mental Status/ Behavioural
- ❑ Nutrition/Hydration

Activity/Participation/Functional Changes
- ❑ ADL
- ❑ Transfers
- ❑ Home/Community Safety

Environmental Changes
- ❑ Organizational/Unit Protocols/ Processes
- ❑ Discharge Destination
- ❑ Social/Family Supports

R — Make **RECOMMENDATION**

Based on this assessment, I request that:
- ❑ we discontinue/continue with .....
- ❑ we prepare for discharge OR extend discharge date
- ❑ you approve recommended changes to treatment plan/goals including .....
- ❑ you reassess the patient's .....
- ❑ the following tests/assessments be completed by .....
- ❑ the patient be transferred out to…/be moved to .....
- ❑ you inform other team members/family/patients about change in plans
- ❑ I recommend that we modify team protocols in the following ways .....

To be clear, we have agreed to… Are you ok with this plan?
- ❑ I would like to hear back from you by .....
- ❑ I will be in contact with you about this issue by .....

Source: Toronto Rehabilitation Institute.

SBAR

Situation

Background

Assessment

Recommendation

Use of SBAR tools

- Shift to shift report
- Transfer forms
- Telephone conversation guide
- Computer Documentation screens

IPSG 3

Safety of high alert medication

Key elements: high alert/ high risk medications – concentrated electrolytes – look alike/ sound alike.

Safe Medication Practices

- 4 of 5 US adults take at least 1 medication (OTC).
- Almost a third take at least 5 different medications.
- Medical cost for medication related injuries amounts to $3.5 billion per year.

Institute for Safe Medication Practices

A Nonprofit Organization Educating the Healthcare Community and Consumers About Safe Medication Practices

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

A federally ce
Patient Safety Organiz

Se

Here's what's new!

HIMSS 11 Annual Conference and Exhibition



FDA/ISMP Safe Medication Management Fellowship Program

Upcoming ISMP Webinars

Improving Medication Safety through Effective Error Reporting

Wednesday, February 9, 2011
from 1:30pm – 3:00pm EST
Click here for more information

Safe Injection Practices: A Call to Action

Education & Awareness

- Newsletters
- Consulting Services
- Educational Programs
- Professional Development
- Self Assessments
- Consumers

Medication Safety Tools & Resources

- **NEW** Standard Concentrations of Neonatal Drug Infusions
- FDA and ISMP List of Drug Names with Tall Man Letters
- Guidelines for Standard Order Sets
- Tool to assess risk in community pharmacy
- Quarterly Action Agenda (Free CE)
- High–Alert Medication List
- Updated Confused Drug Name List
- Community Pharmacy Medication
- Articles of Interest
- List of Products with Drug Name Suffixes
- Error–Prone Abbreviation List
- Pathways for Medication Safety
- ISMP Guidelines
- "Do Not Crush" List
- Improving Medication Safety with Anticoagulant Therapy
- ISMP and Doctor's Digest iPhone app.

Report Medication Erro

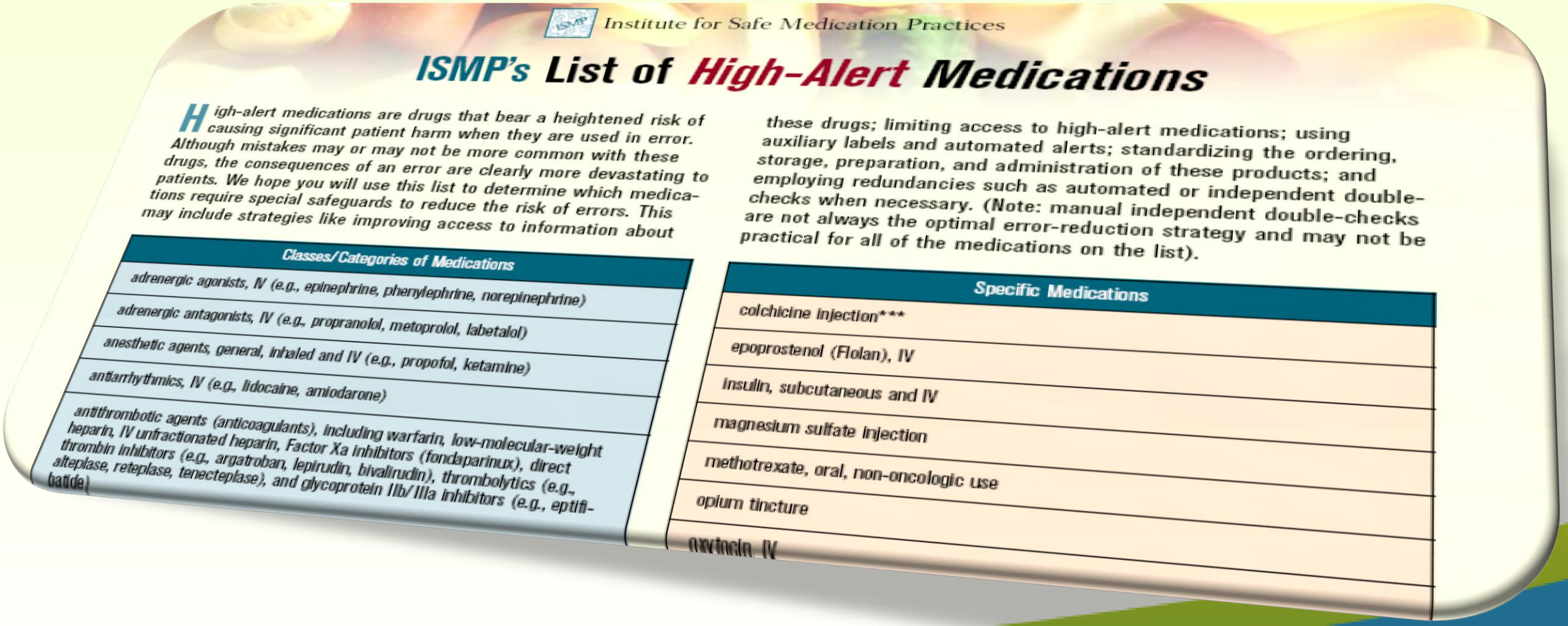
Report your medicatior error or safety concern online. Be sure to inclu all requested informatic

Report Now

ISMP QuarterWatc
Monitoring MedWatch Re



Team Up to Prevent Er
2011 ISMP Medication S



Institute for Safe Medication Practices

ISMP's List 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. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors. This may include strategies like improving access to information about these drugs; limiting access to high-alert medications; using auxiliary labels and automated alerts; standardizing the ordering, storage, preparation, and administration of these products; and employing redundancies such as automated or independent double-checks when necessary. (Note: manual independent double-checks are not always the optimal error-reduction strategy and may not be practical for all of the medications on the list).

Classes/Categories of Medications
adrenergic agonists, IV (e.g., epinephrine, phenylephrine, norepinephrine)
adrenergic antagonists, IV (e.g., propranolol, metoprolol, labetalol)
anesthetic agents, general, inhaled and IV (e.g., propofol, ketamine)
antiarrhythmics, IV (e.g., lidocaine, amiodarone)
antithrombotic agents (anticoagulants), including warfarin, low-molecular-weight heparin, IV unfractionated heparin, Factor Xa inhibitors (fondaparinux), direct thrombin inhibitors (e.g., argatroban, lepirudin, bivalirudin), thrombolytics (e.g., alteplase, reteplase, tenecteplase), and glycoprotein IIb/IIIa inhibitors (e.g., eptifibatide)

Specific Medications
colchicine injection***
epoprostenol (Flolan), IV
insulin, subcutaneous and IV
magnesium sulfate injection
methotrexate, oral, non-oncologic use
opium tincture
oxytocin, IV


POTASSIUM CHLORIDE
POTASSIUM CHLORIDE
POTASSIUM CHLORIDE
POTASSIUM CHLORIDE
40 mEq



Figure 1. Package Labels **WITHOUT** Tall Man Lettering. Image provided courtesy of ISMP.





Look-alike vials have similarly colored labels and caps.



WHO's Patient Safety Solutions

Table 1 – Examples of confused drug name pairs in selected countries
Brand name is shown in italics—Nonproprietary name is shown in bold

Country	***Brand name*** **(Nonproprietary name)**	***Brand name*** **(Nonproprietary name)**
Australia	*Avanza* **(mirtazapine)**	*Avandia* **(rosiglitazone)**
	Losec **(omeprazole)**	*Lasix* **(frusemide)**
Brazil	*Losec* **(omeprazol)**	*Lasix* **(furosemida)**
	Quelicin **(succinilcolina)**	*Keflin* **(cefalotina)**
Canada	*Celebrex* **(celecoxib)**	*Cerebyx* **(fosphenytoin)**
	Losec **(omeprazole)**	*Lasix* **(furosemide)**
France	**fluoxétine**	*Fluvoxamine*
	Reminyl **(galantamine hydrobromide)**	*Amarel* **(glimepiride)**
Ireland	*Losec* **(omeprazole)**	*Lasix* **(furosemide)**
	morphine	**hydromorphone**
Italy	*Diamox* **(acetazolamide)**	*Zimox* **(amoxicillina triidrato)**
	Flomax **(morniflumato)**	*Volmax* **(salbutamolo solfato)**
Japan	*Almarl* **(arotinolol)**	*Amaryl* **(glimepiride)**
	Taxotere **(docetaxel)**	*Taxol* **(paclitaxel)**
Spain	*Dianben* **(metformin)**	*Diovan* **(valsartan)**
	Ecazide **(captopril/hydrochlorothiazide)**	*Eskazine* **(trifluoperazine)**
Sweden	*Avastin* **(bvacizumab)**	*Avaxim* **(hepatitis A vaccine)**
	Lantus **(insulin glargine)**	*Lanvis* **(toguanine)**

The Joint Commission

May 2005

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Additional Abbreviations, Acronyms and Symbols
(For possible future inclusion in the Official "Do Not Use" List)

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for U (units) when poorly written	Write "ml" or "milliliters"
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

Adverse drug event

"An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment"

- 10%-20% errors only in healthcare are reported. 90%-95% of them with no patient harm.
- FMEA
- RCA

Medication error
Adverse Drug Event (ADE)

- Potential ADE
- Preventable ADE
- Non-preventable ADE

Common sources of medication errors:

- Drug-related
- Diagnostic-related
- Equipment failure
- Blood transfusion related
- Misinterpretation of medication order

IHI / HAAD

Health Authority – Abu Dhabi		هيئـــة الصحة - أبوظبي
	Division/Department/Section: PHP/PHM	Reference Number: PHP/PHM/P0002/09
	Subject: Reporting Medication Errors.	Issue Date: May 2009
		Revision Date: May 2011
		Version: 1

Appendix 2
Medication error severity Classification

Category A	Circumstances or events that have the capacity to cause error
Category B	An error occurred but the error did not reach the patient
Category C	An error occurred that reached the patient but did not cause patient harm
Category D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and /or required intervention to preclude harm.
Category E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
Category F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.
Category G	An error occurred that may have contributed to or resulted in permanent patient harm
Category H	An error occurred that required intervention necessary to sustain life.
Category I	An error occurred that may have contributed to resulted in patient death.

Drug Information Online
Drugs.com

Browse all medications A B C D E F G H I J K L M N O P Q R S T U V W X Y Z Advanced Search Phonetic Search

enter a search term Search

Drugs A-Z | Pill Identifier | Interactions Checker | News | Health Professionals | Q & A | Mednotes | Apps



Featured Condition

Could your pain be related to Rheumatoid Arthritis?

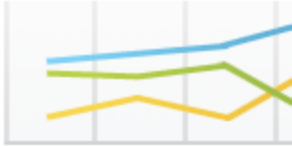
Learn about the signs and symptoms of Rheumatoid Arthritis and the options available for treatment.

Learn More

- Treating RA Pain
- Chemotherapy
- Pill Identifier
- Interactions Checker
- Symptom Checker
- Medical Transcription

Sign In or

Top 100 Drug



U.S. Prescriptio Sales Data

Updated Quarterly

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FDA Consumer U

• Drops Sprays

Featured Services

A to Z Drug List
Drugs by Condition
Pill Identifier
Drug Side Effects
Drug Dosage
Interactions Checker
OTC Database NEW
Medical Conferences
Health Guides
Symptom Checker
FDA Consumer Updates
Medication Record

Welcome to Drugs.com

Drugs.com is the most popular, comprehensive and up-to-date source of drug information online. Providing free, peer-reviewed, accurate and independent data on more than 24,000 prescription drugs, over-the-counter medicines & natural products. Find helpful tools, wallet size personal medication records, mobile applications and more

NEWS | REFERENCE | EDUCATION | Log In | Regist

Medscape

News SEARCH

Username Password Log In REMEMBER ME

New Users: *FREE* Registration! Forgot username? Forgot password?

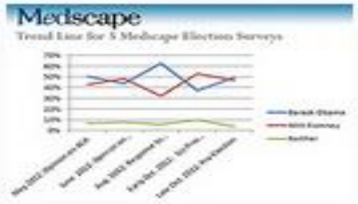
News, Perspectives & Full-text Journal Articles

Specialty Sites

- Allergy & Clinical Immunology
- Anesthesiology
- Cardiology
- Critical Care
- Dermatology
- Diabetes & Endocrinology
- Emergency Medicine
- Family Medicine
- Gastroenterology
- General Surgery
- Hematology-Oncology
- HIV/AIDS



Bed Bugs in Healthcare Settings
Infection Control and Hospital Epidemiology, November 1, 2012



The Last Medscape 2012 Election Survey
Medscape Internal Medicine, November 1, 2012



Fungal Infection Outbreak: What Should Physicians Be Doing?
CDC Expert Commentary, October 31, 2012

News



Topical Ivermectin

Perspectives



Adult Food Allergy:

Breaking medical news in 35 specialties

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DRUG
INFORMATION

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iPhone | iPad





IPSG 4

Correct site, procedure, surgery.

Key elements: site marking – time out

TIME OUT



Patient safety

Patient safety
Research
Campaigns
Education & training
Implementing change
Patient engagement
Information centre
News and events

Campaigns

WHO Patient Safety campaigns

A core part of WHO Patient Safety work is related to our Global Patient Safety Challenges. These Challenges are international campaigns which bring together expertise and evidence on important aspects of patient safety and formulate recommendations to ensure the safety of patients receiving care globally.

WHO Patient Safety works to make these recommendations widely available and provides tools to implement the recommendations in a variety of health-care settings worldwide.

There are currently two Global Patient Safety Challenges. You can read more about these by accessing the links below.



Clean Care is Safer Care
The first Global Patient Safety Challenge works in partnership with the health communities throughout the world and other related organizations to ensure that sustainable hand hygiene improvement remains on the international and national health agendas.



Safe Surgery Saves Lives
The goal of the second Global Patient Safety Challenge is to improve the safety of surgical care in all health-care settings. The WHO Surgical Safety Checklist improves compliance with standards and decreases the incidence of complications.

ABOUT US

WHO Patient Safety



HIGHLIGHTS

Global pulse oximetry project



Hand hygiene webinar with Didier Pittet



PUBLICATIONS & MEETING REPORTS

WHO Guidelines on Hand Hygiene in Health Care - Summary
pdf, 2.81Mb

World Health Organization

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ►►►►►►►►►►

SIGN IN

- ☐ **PATIENT HAS CONFIRMED**
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ **SITE MARKED/NOT APPLICABLE**
- ☐ **ANAESTHESIA SAFETY CHECK COMPLETED**
- ☐ **PULSE OXIMETER ON PATIENT AND FUNCTIONING**

DOES PATIENT HAVE A:

KNOWN ALLERGY?
- ☐ NO
- ☐ YES

DIFFICULT AIRWAY/ASPIRATION RISK?
- ☐ NO
- ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
- ☐ NO
- ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

Before skin incision ►►►►►►►►►►►►►►

TIME OUT

- ☐ **CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE**
- ☐ **SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM**
  - PATIENT
  - SITE
  - PROCEDURE

ANTICIPATED CRITICAL EVENTS

- ☐ **SURGEON REVIEWS:** WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ **ANAESTHESIA TEAM REVIEWS**: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ **NURSING TEAM REVIEWS:** HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
- ☐ YES
- ☐ NOT APPLICABLE

IS ESSENTIAL IMAGING DISPLAYED?
- ☐ YES
- ☐ NOT APPLICABLE

Before patient leaves operating room

SIGN OUT

NURSE VERBALLY CONFIRMS WITH THE TEAM:

- ☐ **THE NAME OF THE PROCEDURE RECORDED**
- ☐ **THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT** (OR NOT APPLICABLE)
- ☐ **HOW THE SPECIMEN IS LABELLED** (INCLUDING PATIENT NAME)
- ☐ **WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED**
- ☐ **SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT**

THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

IPSG 5

Reduce healthcare associated infection

Key elements: hand washing

CDC Home

Centers for Disease Control and Prevention

Your Online Source for Credible Health Information

A-Z Index A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

Hand Hygiene in Healthcare Settings

Hand Hygiene in Healthcare Settings provides healthcare workers and patients with a variety of resources including guidelines for providers, patient empowerment materials, the latest technological advances in hand hygiene adherence measurement, frequently asked questions, and links to promotional and educational tools published by the WHO, universities, and health departments.



Topics...



Hand Hygiene Basics
Overview, Basic Concepts on Hand Hygiene...



Guidelines
Guidelines...



Hand Hygiene Training
Interactive Training, Educational Resources...



Patient Materials
Posters and brochures for patients...



Promotional Campaigns
Podcast and video...



Measurement
Measuring Hand Hygiene Adherence...

iScrub Application

iScrub

iScrub Application »

Patient safety

Patient safety
Research
Campaigns
Education & training
Implementing change
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Information centre
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Campaigns

WHO Patient Safety campaigns

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Hand hygiene webinar with Didier Pittet



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WHO Guidelines on Hand Hygiene in Health Care - Summary
pdf, 2.81Mb

World Health Organization | Patient Safety

A World Alliance for Safer Health Care

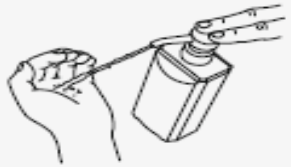
WHO Guidelines on Hand Hygiene in Health Care: a Summary

First Global Patient Safety Challenge
Clean Care is Safer Care



Duration of the entire procedure: 20-30 seconds

1a



Apply a palmful of the product in a cupped hand, covering all surfaces;

1b



2



Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4



Palm to palm with fingers interlaced;

5



Backs of fingers to opposing palms with fingers interlocked;

6



Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Once dry, your hands are safe.

Duration of the entire procedure: 40-60 seconds

0



Wet hands with water;

1



Apply enough soap to cover all hand surfaces;

2



Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4



Palm to palm with fingers interlaced;

5



Backs of fingers to opposing palms with fingers interlocked;

6



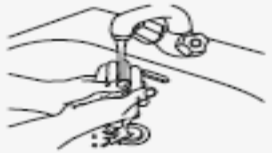
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Rinse hands with water;

9



Dry hands thoroughly with a single use towel;

10

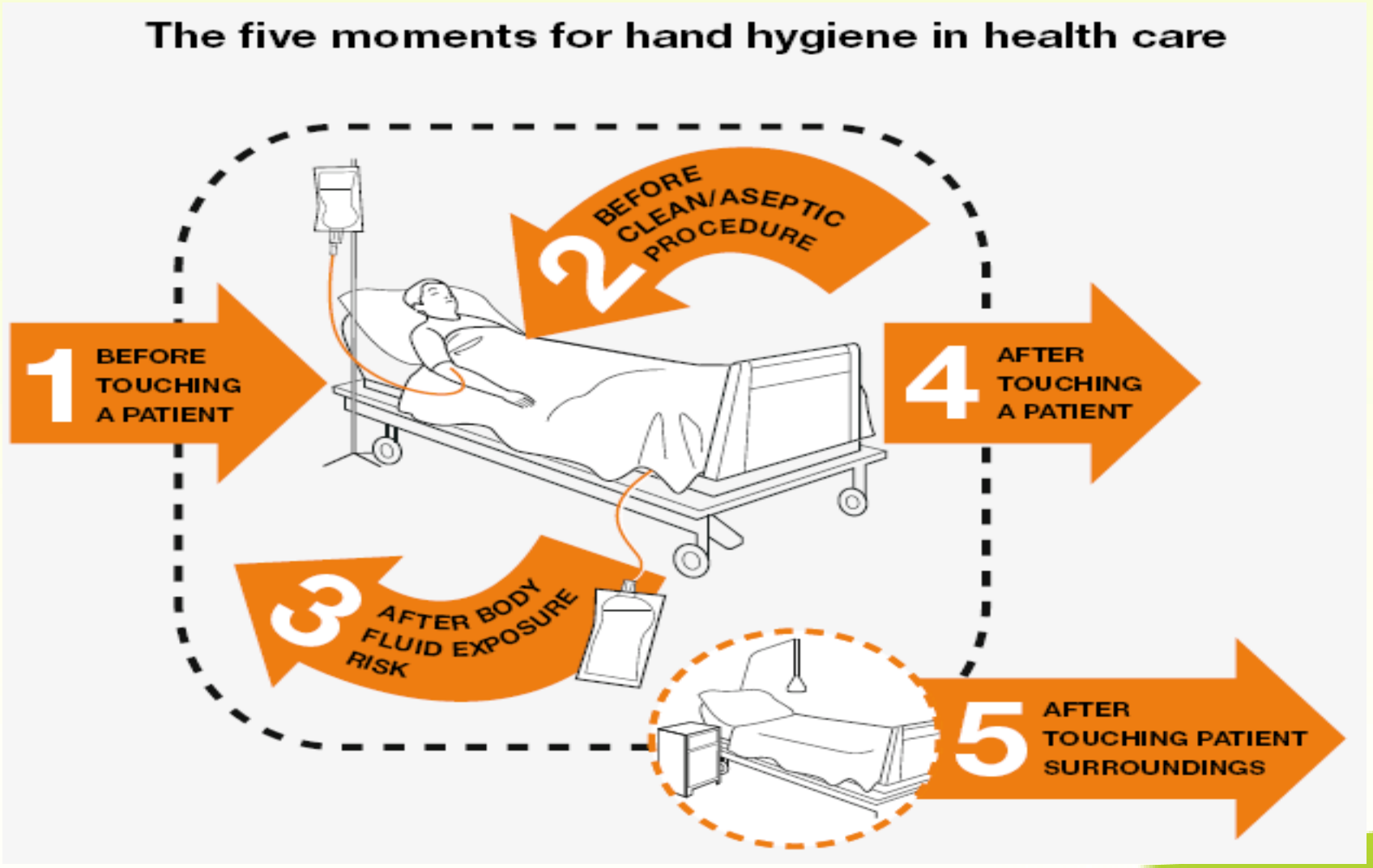


Use towel to turn off faucet;

11



Your hands are now safe.


The five moments for hand hygiene in health care
1
BEFORE TOUCHING A PATIENT
2
BEFORE CLEAN/ASEPTIC PROCEDURE
3
AFTER BODY FLUID EXPOSURE RISK
4
AFTER TOUCHING A PATIENT
5
AFTER TOUCHING PATIENT SURROUNDINGS

IPSG 6



Reduce harm resulting from falls

Key elements: assessment/ reassessment

Teamwork for Patient Safety: NURSING



Role of nurse in pt. safety:

- Creating the vision
- Fostering collaboration
- Data competency, analytic skills



Clinical Practice Guidelines (CPG)

- Main purpose:

- To minimize variations

Clinical Practice Guidelines (CPG)

- Adoption & Adaptation

Clinical Practice Guidelines (CPG) contents

- 1st section: pt. attributes: symptoms, signs
- 2nd section: algorithm: process flowchart
- 3rd section: footnotes: extra-explanation
- 4th section: data collection forms (for evaluation).


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NGC offers Syntheses of selected guidelines that cover similar topic areas, and Expert Commentary on issues of interest and importance to the clinical guideline community.
Start your search by typing keywords into the search box on this page, or use the NGC Brows
or Detailed Search features.
NGC News
What's New this Week
New Synthesis: Diagnosis and Management of Pediatric Urinary Tract Infection (UTI).
New/updated guidelines: EAU, NHFA, SIGN, and UPHS.
New Submission: CDC/HRSA/NIH have updated the guidelines for the use of antiretrovir
agents in pediatric HIV infection.
Recent U.S. Food and Drug Administration (FDA) Advisories
February 26, 2009: Metoclopramide-Containing Drugs

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Providing national guidance on promoting good health and preventing and treating ill health

Welcome to the National Institute for Health and Clinical Excellence

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

Read more about NICE

Using guidance

NICE helps health professionals implement our guidance by providing tools such as cost templates, audit criteria and slide sets.

- **Implementation tools**
- **Commissioning guides - including tool tutorials**
- **Optimal practice review: recommendation reminders**

Latest guidance

- **Early and locally advanced breast cancer**
- **Advanced breast cancer**
- **Rheumatoid arthritis**
- **Influenza - zanamivir, amantadine and oseltamivir (review)**

See all latest guidance

In focus: NICE aims to get children and young people more active



Obesity rates among children and young people are at record levels. Keeping physically active is one way to help prevent them getting overweight. Yet the lure of computer games and television – and the fear of letting them go outside to play – means more of them are spending less time being physically active.

Search NICE guidance

Want to know what NICE recommends?

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Web contact
duncan.service@nhs.net
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MANAGEMENT OF OBESITY

DOWNLOAD THE GUIDELINE

- Full guideline (1.61MB)
- Quick reference guide (1.08MB)
- Summary of recommendations (291K)
- Information about Acrobat files

REMIT OF THE GUIDELINE



This guideline provides evidence based recommendations on the prevention and treatment of obesity within the clinical setting, in children, young people and adults. The focus of prevention is on primary prevention, defined here as intervention when individuals are at a healthy weight and/or overweight, to prevent or delay the onset of obesity.

Guideline No 115, ISBN 978 1 905813 57 5
February 2010

SUPPORTING MATERIAL

- Search narrative (103K)

Evidence notes on Surgery for Obesity and Weight Management Programmes for Adults have been produced by NHS QIS

- Evidence Note 19: Surgery for

PATIENT INFORMATION

- See section 20 of the guideline

Ministry of Health Portal ▸ MOH Departments ▸ The Saudi Center for Evidence Based Healthcare (EBHC)

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- About us
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The Saudi Center for Evidence Based Healthcare (EBHC)

Clinical Practice Guidelines

- CPG 1: Deep Vein Thrombosis

Clinical Practice Guideline on the Diagnosis of Suspected First Deep Vein Thrombosis of Lower Extremity

- CPG 2: Venous Thromboembolism

Clinical Practice Guideline on the Treatment of Venous Thromboembolism

- CPG 3: Stroke

Clinical Practice Guideline on Prevention of Venous Thromboembolism in Patients with Stroke

- CPG 4: Stroke

	Volume	Readmission Rate	Physician Champion	LOS Variance
Diabetes Mellitus	20	0.02	Yes	No
Heart Failure	40	0.1	Yes	Yes
Gastro Enteritis	80	0.05	No	Yes
Total Knee Replacement	10	0.02	Yes	No

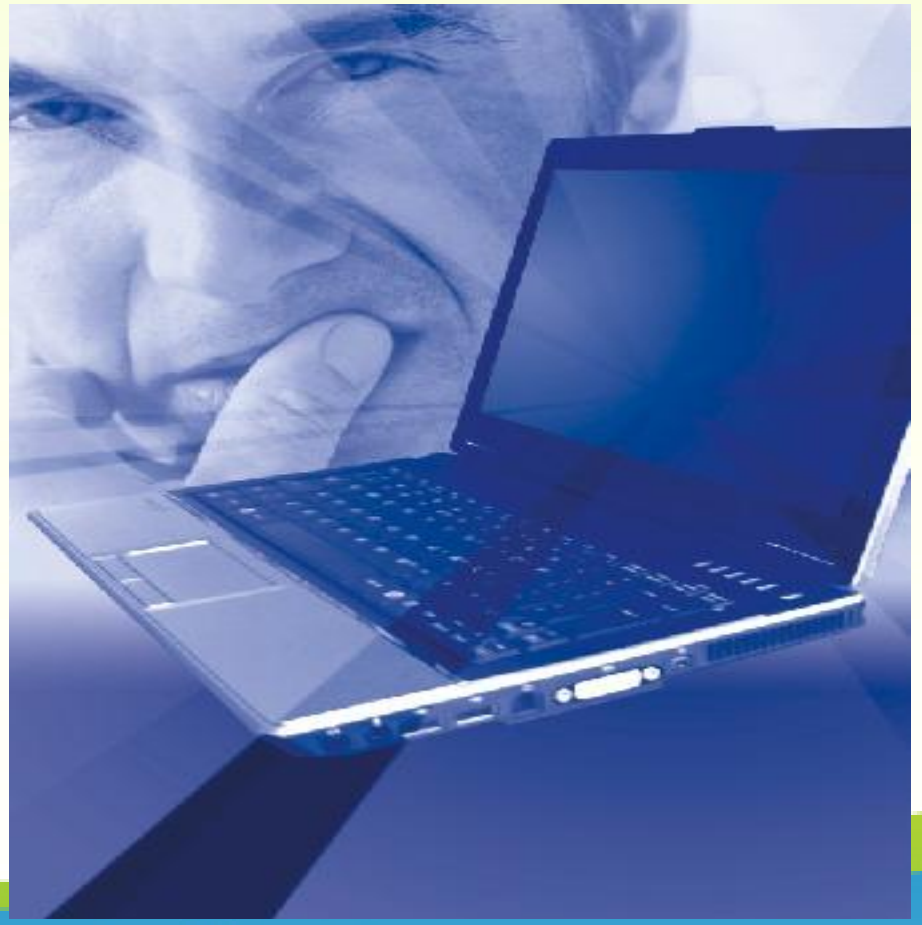
Critical Path: Uncomplicated Coronary Artery Bypass

	PAT Date Day of Week	OPS/DOS Date Day of Week	OR/DOS Date Day of Week	ICU/DOS Date Day of Week
Assessments/ Evaluations	Nursing assessment ___ Anesthesia assessment ___ Inter H&P or letter ___ Chart requirements met ___ Consent ___ Admission note ___	Nursing assessment ___ SDA/OPS 0530-0600 ___ Anesthesia assessment ___ Chart requirements met ___	Nursing assessment ___ Chart requirements met ___ Anesthesia assessment ongoing ___	Nursing assessment 7–3 ___ 3–11 ___ 11–7 ___ RT assessment Post-op VS till stable ___ VS protocol ___
Tests	Routine UA ___ EKG ___ Chest x-ray (PA & LAT) ___ Chem 20, CBC, PTT, PT, Plt count ___ Type & cross 4 units/6 units ___ Pregnancy test if ind. ___		ABG's ongoing ___ Heart profile: RBS, LYTES, Ca, Hgb, Hct ___ Co-Oximetry ___	Chest x-ray ___ EKG ___ ABG, CBC, CUN, Cr, PT, PTT, CPK, LDH, Isos ___
Consults	Confirm medical evaluation complete ___			Pulmonary Cardiology Co-manage ___ Cardiac Rehab ___
Treatments		Accurate height/weight ___ Shave/prep ___ Nasal 0_2 ___	Insert PA catheter ___ Insert A-line ___ Apply cardiac monitor ___ Pulse oximetry ___ IABP standby ___ Intubate/ventilator ___ Prep ___ Drape ___ Surgery/bypass ___ Autotransfuser ___ Chest tubes ___ Pacer wires ___ Warming blanket ___ Dressings ___	Bed weight ___ Nurse initiated C&DB ___ Dressing assessed ___ Ventilator ___ RT treatments ___ Autotransfusion ___ Pulse oximetry ___ Hemodynamic monitoring ___ Chest tubes ___ Pacer standby ___ Warming blanket ___ Cardiac monitoring ___
Medications	Confirm availability of autologous blood if ordered ___	Start 2 IV peripheral lines ___ Prophylactic antibiotic pre-op ___	Anesthesia sedation ___ Blood therapy ___	IV ___ IV meds ___ Vasopressors ___ Post-op sedation ___
Activity		ABR ___	ABR ___	ABR ___ Card Rehab passive ROM ___
Diet		NPO ___	NPO ___	NPO ___

Critical Path: Uncomplicated Coronary Artery Bypass, *continued*

	PO Day 1 Date Day of Week	PO Day 2 Date Day of Week	PO Day 3 Date Day of Week	PO Day 4 Date Day of Week	PO Day 5 Date Day of Week
Assessments/ Evaluations	Nursing Assessment 7–3 ___ 3–11 ___ 11–7 ___ RT assessment ___ Nutritional screen ___ VS protocol ___	Nursing Assessment 7–3 ___ 3–11 ___ 11–7 ___ VS protocol ___	Nursing Assessment 7–3 ___ 3–11 ___ 11–7 ___ VS protocol ___	Nursing Assessment 7–3 ___ 3–11 ___ 11–7 ___ VS protocol ___	Nursing Assessment 7–3 ___ 3–11 ___ 11–7 ___ VS protocol ___
Tests	Pre/post extubation ___ ABG's ___ CBC, BUN, Cr, LYTES, CPK, LDH, SGOT, PT, PTT, Plt count ___ EKG ___ Chest x-ray ___	EKG ___ CBC, BUN, Cr, LYTES, CPK, LDH, SGOT, PT, PTT, Plt count ___ Chest x-ray ___	EKG ___ CBC, LYTES ___ Chest x-ray ___		
Consults	Pulmonary rehab ___				
Treatments	Wean/extubate within 12 hours ___ Incentive spirometry ___ Chest physical therapy ___ Weight 06:00 ___ O_2 therapy ___ Dressing changes ___ Cough & deep breathe ___ Cardiac monitoring ___	Pulse oximetry prn ___ Weight 06:00 ___ Incision checks ___ DC dsg prior to transfer ___ Assess for DC chest tubes ___ pacer lines ___ Cardiac monitoring ___ O_2 therapy per RT protocol ___	Weight 06:00 ___ Incision checks ___ Cardiac monitoring ___ O_2 therapy per RT protocol ___	Weight 06:00 ___ Incision checks ___ Cardiac monitoring ___	Weight 06:00 ___ Incision checks ___ Cardiac monitoring ___
Medications	IV ___ IV pain meds ___ Blood therapy ___ Vasopressor ___ Post-op sedation ___	IM to PO pain RX ___ DC IV lines main 1 peripheral IV ___ Routine meds ___	Routine meds ___ Change to heplock ___ PO meds ___	Routine meds ___ DC heplock ___ PO meds ___	Routine meds ___ PO meds ___
Activity	Up in chair ___ Cardiac rehab ___ Pulmonary rehab ___	Amb in room with assistance ___ Cardiac rehab ___ Pulmonary rehab ___	Amb in hall ___ Cardiac rehab ___	Amb in hall ___ Cardiac rehab/TM ___	Amb in hall ___ Shower ___ Cardiac rehab/TM ___
Diet	Cl. liq p extubation ___ Prog to 4 gm Na AHA low cholesterol ___	4 gm Na AHA ___	4 gm Na AHA ___	4 gm Na AHA ___	4 gm Na AHA ___

IT & patient safety



- Electronic Health Record (EHR).
- CPOE
- Bar-coded ID bands (Radio-frequency)
- Bar-coded medication administration systems: Increase accuracy of medication administration, availability of management tracking and reporting tools, enhanced documentation and greater pt safety
- Infant security systems
- Pt safety software (incident reporting)











Resources for Patient Safety



WHO



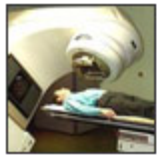
Multi-professional Patient Safety Curriculum Guide
The comprehensive Multi-professional Patient Safety Curriculum Guide assists universities and schools in the fields of dentistry, medicine, midwifery, nursing and pharmacy to teach patient safety.



Training leaders in Patient Safety Research
The Core Competencies for Patient Safety Research provide a framework for the ongoing education and training of patient safety researchers worldwide.



Learning from Error - workshop materials
Booklet and video in 6 languages explores how multiple weaknesses present within the health-care system can lead to error and helps you gain an insight into the underlying causes of such events.



Radiotherapy risk profile
pdf, 686kb



Training materials in infection control



WHO Surgical Safety Checklist and Manual
Resources to help health-care professionals improve the safety of surgical care for their patients by ensuring adherence to proven standards of care.



Introductory Course of Patient Safety
A free on-line course is available to introduce the basic elements of patient safety research.

Disclosure of errors (Josie King error)

- Just culture supports the disclosure of both successes and failures.

- **Risk Management Pearls on**

Disclosure of Adverse Events

ASHRM AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT



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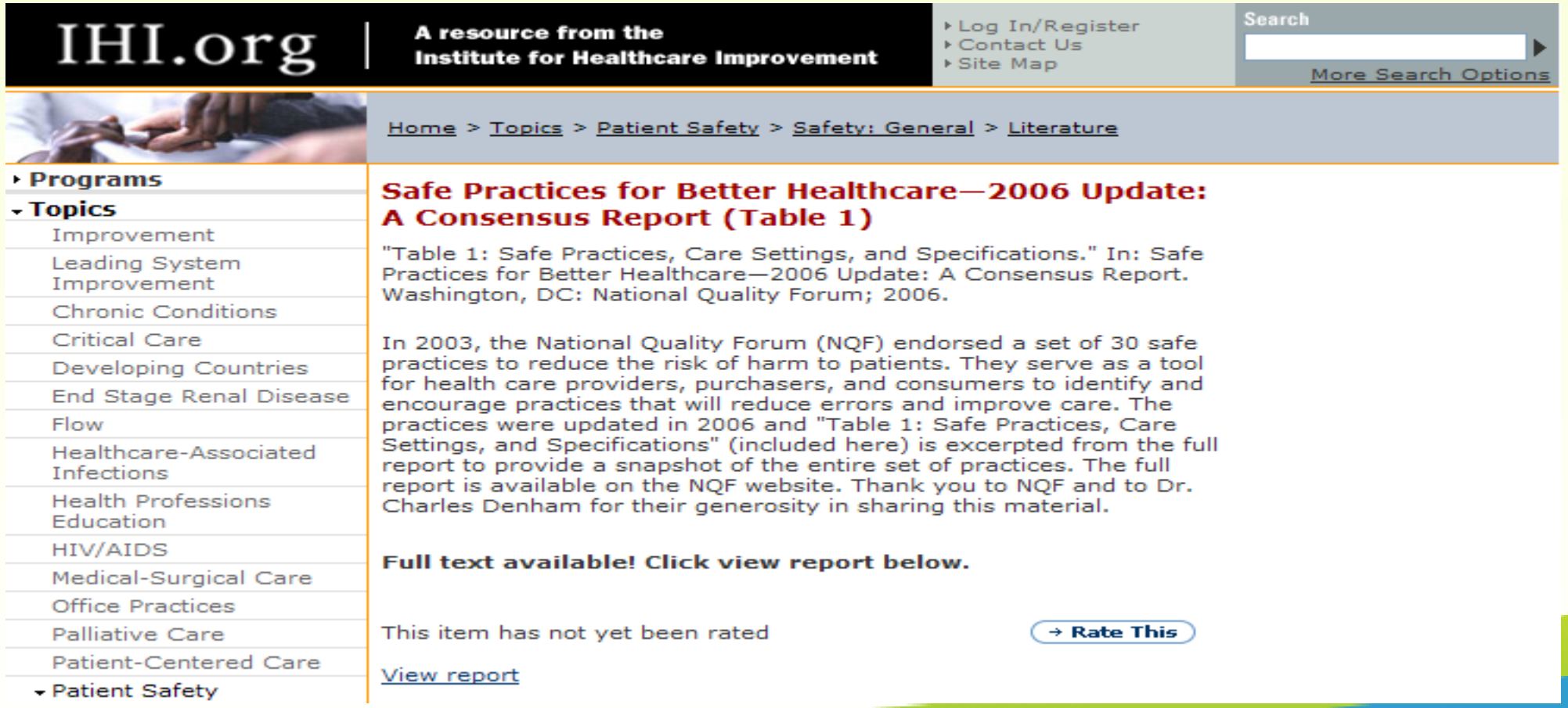


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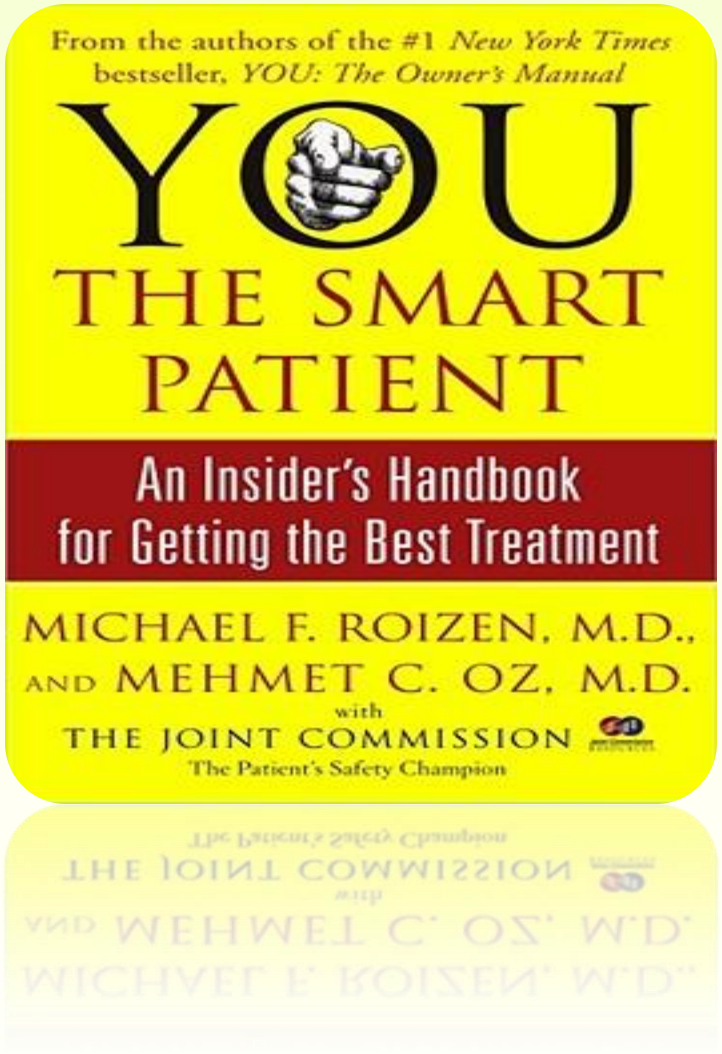
Welcome to Sorry Works!

Sorry Works! began in early 2005 as an advocacy organization focused on persuading physicians, hospitals, and insurers to consider disclosure as an alternative solution to the medical malpractice crisis. Sorry Works! received wide-spread media attention in outlets such as the *Associated Press, CNBC, Chicago Tribune, American Medical Association News,* and other major publications and outlets. Medical, insurance, and legal professionals began seeing the awesome potential for disclosure and came back to Sorry Works! with two

Safe Practices for Better Healthcare update 2006, NQF, consensus report



SPEAK UP


From the authors of the #1 New York Times bestseller, YOU: The Owner's Manual
YOU
THE SMART PATIENT
An Insider's Handbook for Getting the Best Treatment
MICHAEL F. ROIZEN, M.D.,
AND MEHMET C. OZ, M.D.
with
THE JOINT COMMISSION
The Patient's Safety Champion

SPEAK UP

The Joint Commission

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Friday 7:41 CST, January 7, 2011

Speak Up Initiatives

Speak Up Brochures

- Help Prevent Errors in Your Care
- Five Things You Can Do To Prevent Infection
- Tips for Your Doctors Visit
- Reduce Your Risk of Falling
- Diabetes - Five Ways to be Active in Your Care at the Hospital
- Prevent Errors in Your Child's Care

The Joint Commission's award-winning patient safety program

To order Speak Up materials call 1-877-223-6866, or visit the JCR Web Store. For more information see "About the Speak Up Program."

Speak Up: Help Avoid Mistakes in Your Surgery



Mistakes can happen during surgery. Surgeons can do the wrong surgery. They can operate on the wrong part of your body. Or they can operate on the wrong person. Hospitals and other... Learn More

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PAUSE | Back | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 | Next

Speak Up Posters

- Universal Protocol (Poster)
- Speak Up: Help Prevent Errors in Your Care (Poster)
- Speak Up: Five Things You Can Do To Prevent Infection (Poster)
- Speak Up: Help Avoid Mistakes With Your Medicines (Poster)

View More

Speak Up Brochures - Accreditation Programs

- Speak Up: Behavioral Health Care
- Speak Up: Home Care

Books

BOOK LIST

Lessons Learned in changing healthcare... and how we learned them

Introduction: Moving Forward Together through Reflection and Sharing
Paul Batalden

Chapter 1: Walk the Talk
Carolyn Kerrigan

Chapter 2: Listening to Those We Seek to Help
Harlan M. Krumholz

Chapter 3: Teaching Others to Lead Change
Linda A. Headrick

Chapter 4: Raising Our Heads Out of the Sand
Gregg S. Meyer

Chapter 5: Problems Worth Attacking May Attack Back
Richard A. Deyo

Chapter 6: Learning Another Language
Peter Margolis



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Editorial Notebook

eLetters

NPSF
National Patient Safety Foundation®

Creating a world where patients and those who care for them are free from harm

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CPPS CERTIFIED PROFESSIONAL IN PATIENT SAFETY

REVIEW COURSE WEBINAR

Demonstrate your expertise in patient safety – become a CPPS.
This webinar can help you prepare for the certification exam.

Thursday, September 24, 2015 | 10:00am–5:00pm

Find out more and register now

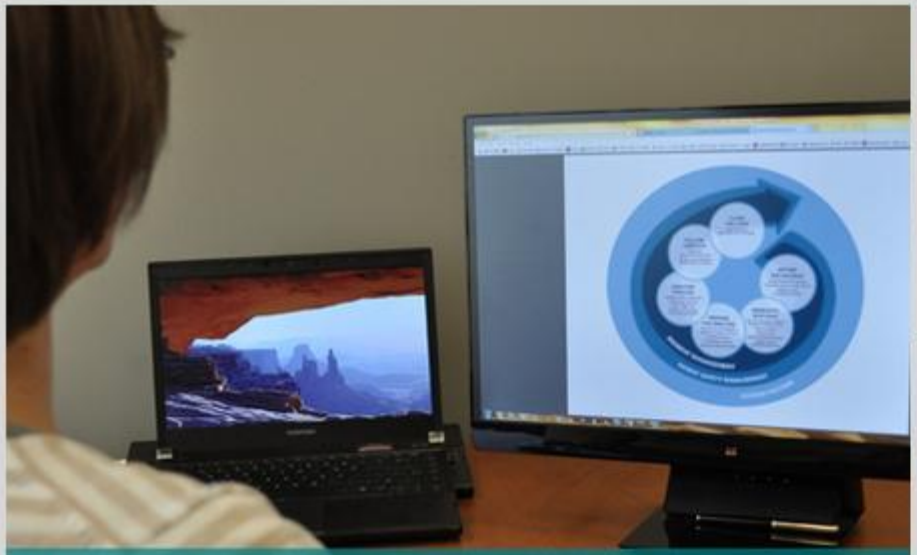


Discussion Forum Français

cpsi icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

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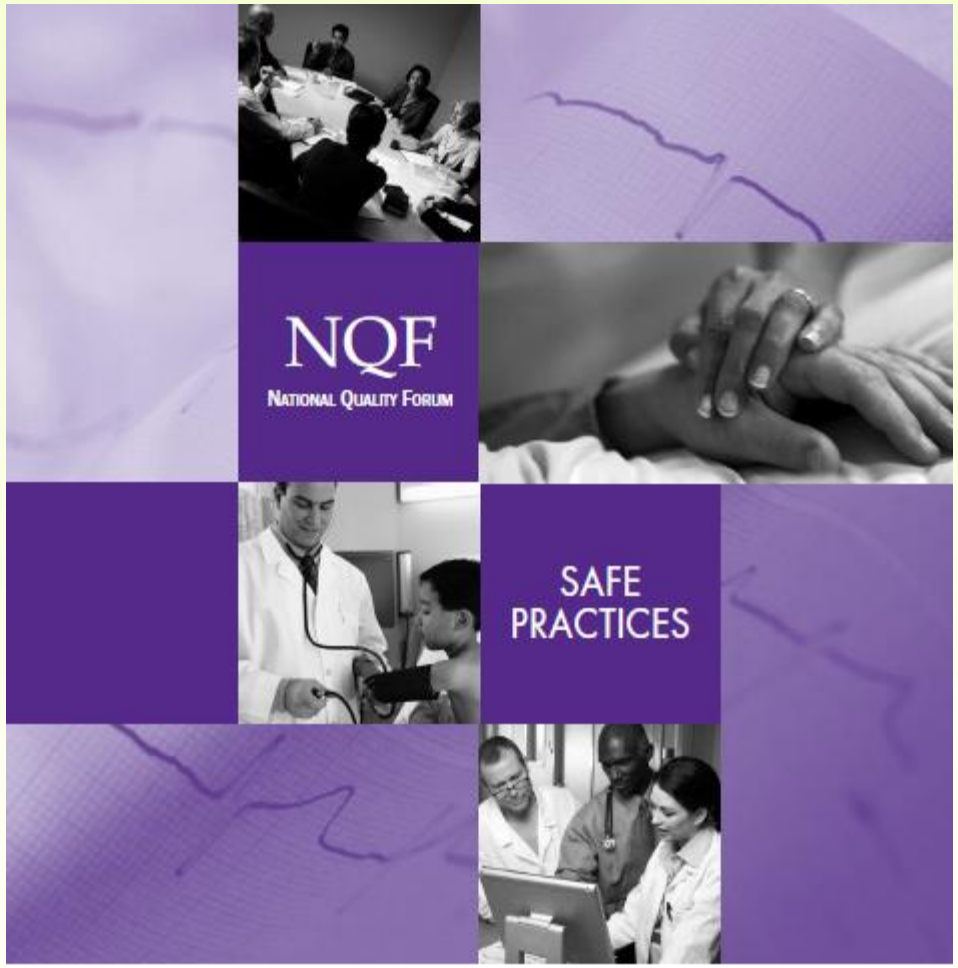
Patient Safety Incident Management Toolkit
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Choosing Wisely Canada
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Medication Reconciliation
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Meet new PFPSC co-chair Denise Klavano
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Safe Practices for Better Healthcare–2009 Update

A CONSENSUS REPORT

Clinicians & Providers
Education & Training
Hospitals & Health Systems
Prevention & Chronic Care
Quality & Patient Safety
- AHRQ's Healthcare-Associated Infection Program
- Comprehensive Unit-based Safety Program (CUSP)
- Partnership for Patients
- Patient and Family Engagement
- Patient Safety Measure Tools & Resources

Hospital Survey on Patient Safety Culture

In 2004, the Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture, a staff survey designed to help hospitals assess the culture of safety in their institutions. Since then, hundreds of hospitals across the United States and internationally have implemented the survey.

In response to requests from hospitals interested in comparing their safety culture survey results to other hospitals, AHRQ funded the development of a comparative database on the survey in 2006. The database comprises voluntarily submitted data from U.S. hospitals that administered the survey. Comparative database reports were produced in 2007, 2008, 2009, 2010, 2012, and 2014.

Hospital Survey Toolkit

UPDATE ON HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

AHRQ is proposing a pilot test and bridge study data collection effort to test a revised Hospital Survey on Patient Safety Culture (Version 2.0) and new supplemental item set on Health Information Technology Patient Safety.

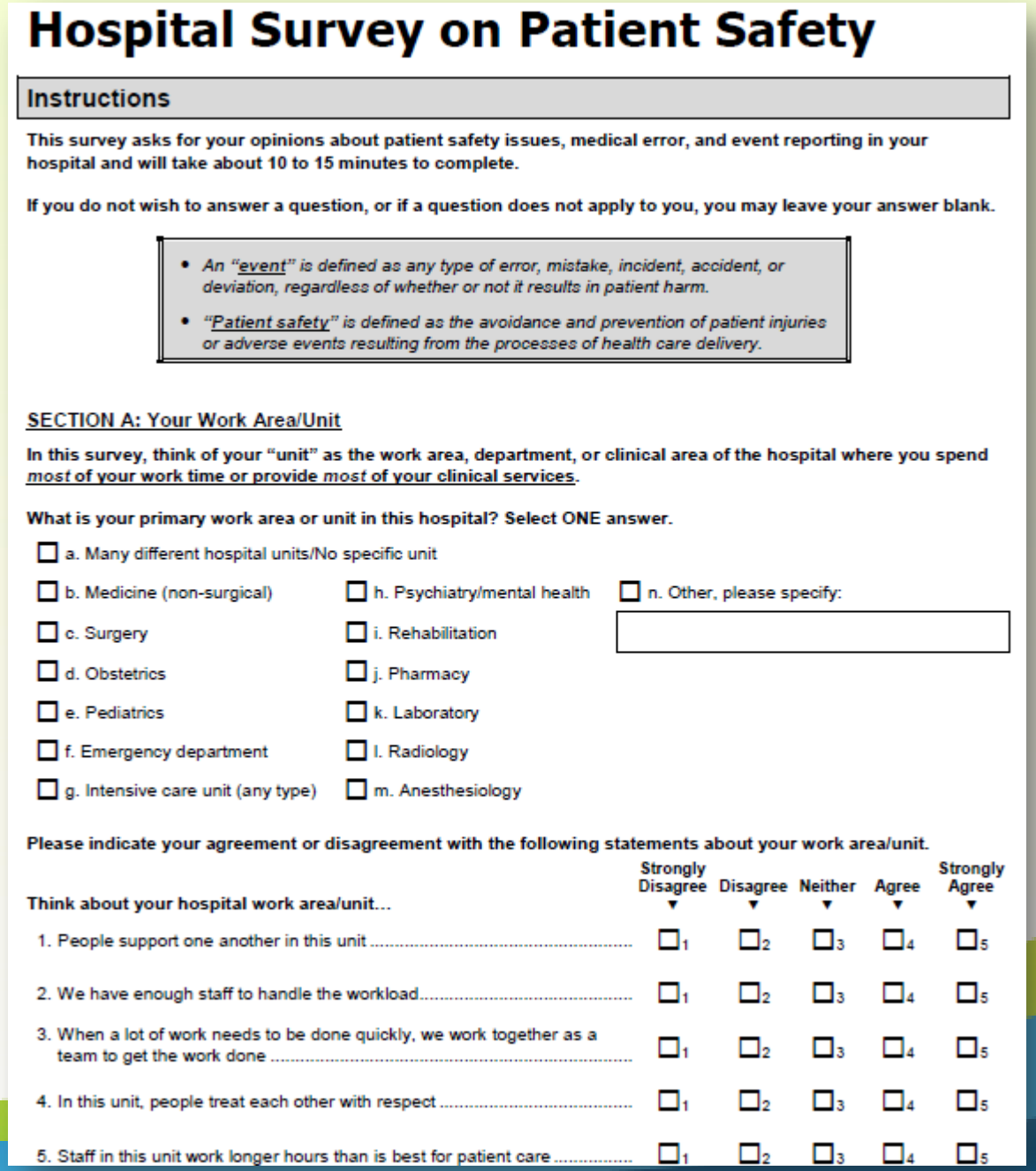
Read more.

RESOURCE LIST

Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture

HSOPS, AHRQ

- Measure the Culture..



Hospital Survey on Patient Safety

Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

- *An "event" is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.*
- *"Patient safety" is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.*

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend *most* of your work time or provide *most* of your clinical services.

What is your primary work area or unit in this hospital? Select ONE answer.

- ☐ a. Many different hospital units/No specific unit
- ☐ b. Medicine (non-surgical)
- ☐ c. Surgery
- ☐ d. Obstetrics
- ☐ e. Pediatrics
- ☐ f. Emergency department
- ☐ g. Intensive care unit (any type)
- ☐ h. Psychiatry/mental health
- ☐ i. Rehabilitation
- ☐ j. Pharmacy
- ☐ k. Laboratory
- ☐ l. Radiology
- ☐ m. Anesthesiology
- ☐ n. Other, please specify: _____

Please indicate your agreement or disagreement with the following statements about your work area/unit.

Think about your hospital work area/unit…	**Strongly Disagree**	**Disagree**	**Neither**	**Agree**	**Strongly Agree**
1. People support one another in this unit	☐1	☐2	☐3	☐4	☐5
2. We have enough staff to handle the workload	☐1	☐2	☐3	☐4	☐5
3. When a lot of work needs to be done quickly, we work together as a team to get the work done	☐1	☐2	☐3	☐4	☐5
4. In this unit, people treat each other with respect	☐1	☐2	☐3	☐4	☐5
5. Staff in this unit work longer hours than is best for patient care	☐1	☐2	☐3	☐4	☐5


Patient safety
assessment manual
World Health
Organization
Regional Office for the Eastern Mediterranean


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منظمة الصحة العالمية
المكتب الاقليمي لشرق المتوسط


Questions
Answers

THANK YOU
and
Keep your Patients Safe