

# PHYSICIAN PATIENT SAFETY TRAINING

## I. WHY IS PATIENT SAFETY GETTING SO MUCH ATTENTION NOW?

In their 1999 report, *To Err is Human*, the Institute of Medicine (IOM) emphasized that most medical errors are systems-related and not usually attributable to individual negligence or misconduct. Since then, patient safety has been a major focus of governmental agencies, consumer groups, and professional organizations. The Patient Safety and Quality Improvement Act of 2005 establishes legal protection against discovery when hospitals report error data to patient safety organizations.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued patient safety goals that all hospitals must achieve, based on the most frequent causes of errors and Sentinel Events throughout the United States. Quality and safe performance measures are planned to be used in a pay-for-performance model by Medicare and other payers. Groups like Leapfrog (a group of large business leaders who are using their purchasing power to influence quality of care) have set quality standards that will be publicly reported to encourage consumerism in healthcare.

## II. WHAT CAN THE PHYSICIAN DO TO IMPROVE SAFETY?

### A. Be aware of and support the JCAHO National Patient Safety Goals (NPSGs):

#### 1. Verify patient identification

Verify the patient's **full name** and **date of birth** prior to any treatment or service. ID verification involves verbal callback when it is part of the pre-procedure "time out" (as described in B. below). Pages in the patient record and paperwork faxed from your office also should include the patient's correctly spelled full name and correct date of birth.

#### 2. Improve communication among caregivers

Verbal/telephone orders require a "**read-back**". The read-back requirement also applies to critical test results. Critical test results are those results that require immediate (<1 hr) communication, acknowledgement and clinical response.

Implement a standardized approach to "**hand off**" communications, including an opportunity to ask and respond to questions. Physician to Physician "sign out" should be performed using standardized profiles developed within individual departments.

As part of improved communication, JCAHO recommends removal of unsafe **abbreviations** listed in the table below\*. The most common violations are:

- a. Lack of leading zero before decimal point. For instance, .5 mg may be interpreted as 5 mg if the decimal point is not seen. Write 0.5 mg instead.
- b. Trailing zero after a decimal point is not allowed. For instance 5.0 mg may be confused with 50 mg if the decimal point is not seen. Write 5 mg instead.
- c. QD, QOD and QID are confused with each other and must not be used anywhere in the medical record.

**\*Do Not Use Abbreviations in table below**

Unacceptable	Description	Acceptable
Dig.	Digitalis/digoxin	Write “digoxin”
DTO	Deodorized/Diluted Tincture of Opium	Write “Deodorized Tincture of Opium” or “Pediatric Morphine Oral Solution 0.4 mg/mL”
gr.	Grain	Use the metric system
IU	International unit	Write “international unit”
Lack of Leading Zero (.Xmg)		Ex: <u>0.3 mg acceptable</u> .3 mg unacceptable
Trailing Zero (X.0 mg)		Ex: <u>3 mg acceptable</u> 3.0 mg unacceptable
MS & MSO <sub>4</sub>	Morphine Sulfate	Write “Morphine”
MgSO <sub>4</sub>	Magnesium Sulfate	Write “Magnesium Sulfate”
Nitro.	Nitroglycerin	Write “Nitroglycerin” or “Nitroprusside”
Qd or QD/qod or QOD/QID	Daily/every other day/4 times day	Write “daily” or “every other day” or “four times daily”
U	unit	Write “units”

*Pocket card copies of this table are available from the Medical Records Department.*

### **3. Medication Safety**

Be aware that concentrated electrolytes, such as potassium chloride and hypertonic sodium, are not stocked in general patient care areas. In the OR, they must be labeled and controlled.

During procedures, label all medications, medication containers and/or basins when a) using more than one med or solution, or b) setting up for the procedure in advance (either yourself or another staff member). Preprinted labels, color-coded by medication groups will be available soon.

### **4. Prevent nosocomial infections**

Wash your hands with soap and water for 15 seconds if they are visibly soiled. If they are not visibly soiled, you may use an alcohol-based hand rub. The use of towelettes for hands is not acceptable.

Mortality review requires the consideration of nosocomial infections as a contributing factor to the patient's death.

### **5. Reconcile medications**

Involve the patient in obtaining a complete list of home medications (including herbals and OTCs) on admission. Reconcile medications on this list with those prescribed throughout the patient's encounter and at discharge. Communicate the reconciled medication list when the patient is transferred to another setting or service. Provide the patient and primary care physician a complete list upon discharge.

### **6. Reduce patient falls**

Assess each patient's risk for falling, including the potential risk associated with the patient's medication. Educate the patient and family about the risk of falls.

### **7. Urge patients to Speak Up**

Encourage patients' active involvement in their own care and to report safety concerns.

### **8. Identify safety risks for your patients**

Assess suicide risk for patients treated for emotional or behavioral disorders.

## **B. Use the *Universal Protocol* to prevent wrong-site surgery or procedures**

Prior to the start of a surgical or invasive procedure, conduct and document a final verification or "time out" to confirm the correct patient, procedure and site, and check any necessary patient positioning, display of radiographs, and required instruments and/or implantables. In the OR, patients may be marked for site/laterality/level by the Attending Physician or his/her designee. However, the final verification of patient identity, surgery/procedure, site/site/level must occur with the involvement of the Attending Physician before the procedure begins.

The time out (including ID/procedure/site *callback*—the call out and confirmation by a second person) applies to all invasive procedures that put the patient at more than minimal risk, regardless of where they are performed in the hospital, except in life-threatening emergencies.

**C. Practice and model good communication skills**

- Encourage participation by all members of the patient care team with a quick explanation prior to surgery of what you plan to do, what the crucial points are, and what equipment you will need. Ask them to speak up if they see a potential problem.
- Provide sufficient information to all members of the care team, and expect the same in return.
- Involve patients and families by listening to them and providing information in a manner they can understand.

**D. Report incidents and near misses**

- Use the Lifespan Intranet:  
On Employee Tools tab, select Occurrence Reporting (upper right corner of the page)
- Participate in intense analyses of such events for system improvement.

**E. Avoid reliance on memory**

- Use protocols, checklists, POM.
- Develop a test results-tracking system for your office practice.

**F. Participate in Hospital programs**

- Attend M&M conferences and departmental quality improvement meetings.
- Contact the Hospital Patient Safety Committee through the Quality Management Department to report system problems and to make suggestions for system improvements.

Name:  
Department:

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**RHODE ISLAND HOSPITAL AND THE MIRIAM HOSPITAL  
PATIENT SAFETY ANNUAL EDUCATION**

**QUESTIONS FOR CLINICIANS**

**1. Which of the following is a National Patient Safety Goal?**

- A. Do not use unsafe abbreviations
- B. A standardized approach should be used for “hand-off” communications
- C. Medication lists should be reconciled at the time of patient transfer
- D. All of the above

**2. Which two identifiers are used for patient identification?**

- A. The patient’s full name and social security number
- B. The patient’s full name and room number
- C. The patient’s full name and date of birth
- D. The patient’s full name and diagnosis

**3. The only exception to the “time out” policy is life-threatening emergencies.**

- A. True
- B. False

**4. The verification of accuracy of communication among caregivers requires “read-back” for which of the following:**

- A. Verbal orders
- B. Critical test results
- C. Telephone orders
- D. All of the above

**5. Critical Test Results are defined as:**

- A. Those results requiring immediate (< 1 hr) clinical action
- B. An unexpected finding with immediate impact on patient care
- C. Test values or conditions that must be communicated & acknowledged in <1 hr
- D. All of the above

**\*6. The correct way to write five milligrams of Morphine Sulfate is:**

- A. 5.0 mg MgSO<sub>4</sub>
- B. 5 mg MgSO<sub>4</sub>
- C. 5.0 mg Morphine Sulfate
- D. 5 mg Morphine Sulfate

**\*7. The correct way to write an order for Digoxin one quarter milligram every day is:**

- A. Digoxin 0.25 mg q.d.
- B. Digoxin 0.25 mg daily

*\*These two questions are required to be answered correctly.*

**8. Mechanisms to prevent wrong site/side surgery or other invasive procedures include:**

- A. Procedure verification process
- B. "Time Out"
- C. Process to mark intended site/side of procedure
- D. All of the above

**9. In the OR, final verification of patient identity, surgery/procedure, site/side/level must occur with the involvement of the Attending Physician.**

- A. True
- B. False

**10. Which of the following are CDC Hand Hygiene recommendations for the prevention of nosocomial infections?**

- A. If visibly soiled, wash hands with soap and water for at least 15 seconds
- B. If not visibly soiled, use Alcohol-based hand rub until dry
- C. Do not use towelettes
- D. All of the above

**11. As part of medication reconciliation, a complete list of medications the patient is to be receiving is checked at any transfer to another service or setting and is given to the patient at discharge.**

- A. True
- B. False

**12. Fall prevention involves:**

- A. A complete initial safety assessment, updated frequently
- B. Patient and family education
- C. Evaluation of medications
- D. All of the above

**13. All medications, medication containers and other solutions must be labeled on and off the sterile field in peri-operative and other procedure settings.**

- A. True
- B. False

**14. JCAHO requires a standardized approach to "hand off" communication, including an opportunity to ask and respond to questions.**

- A. True
- B. False

**15. Patient Safety strategies should include**

- A. Encouraging patients to be actively involved in their own care
- B. Encouraging patients to report safety concerns
- C. Assessing suicide risks for patients treated for emotional or behavioral disorders
- D. All of the above