Patient Safety & Rights
This Happened in a KentuckyOne Health Facility....
#1 Root Cause of Harm is Miscommunication

- Lack of communication
- Inadequate written or verbal communication
- Increase:
  - Times of high stress
  - During critical situations when time is perceived to be of the essence
  - As the number of individuals/providers (handoff) increases
What can you do?

- Listen to the Patient and their Family
- When something doesn’t seem right use this Safety Phrase:

“I have a concern…”
Patient Safety: Not just for Clinicians

• Active Time Outs
• Two identifiers:
  – Ask Patient Name & DOB
• MRI Safety (anyone entering suite)
• Safe, clean environment
• Equipment safety
• Clinician decision support
• Finance
Patient safety is everyone's responsibility!

- Active Time Out
  - Announcement of the “time out” and all activity stops
  - Verification of correct patient, side, site, and procedure
  - Verbal confirmation from everyone involved
  - Announcement of “time out” completion
Patient safety is everyone's responsibility!

- Use two patient identifiers when providing care, treatment, or services.
- STOP and tell your supervisor if you are unable to comply with performing 2 patient identifiers.
MRI is **ALWAYS “ON”**

- Normally safe objects are dangerous in an MRI room, primarily because of the “Projectile Effect”

- Never enter the MRI room unless cleared by the MRI tech
Potential MRI Missiles…

- IV Poles
- Screwdrivers
- Fire Extinguishers
- Guns/Fire Axes
- Wheelchairs
- Pens/Paperclips
- Hammers
- Cleaning equipment
- Name Tag clips
- Scissors
- Jewelry

GREEN MEANS GO

RED MEANS STOP
Safe Medical Devices Act

• Since 1990 hospitals have been Federally required to report incidents where a medical device/implant has caused or contributed to a patient death, serious illness or injury.

• We voluntarily log and report failures in equipment, instruments, or implants through Med Sun which helps the FDA track patterns as a proactive means of stopping serious injuries BEFORE they occur.
When Incidents do Happen they Need to be Reported

- When to complete an incident report:
  - Patient Event
  - Team Member Injury
  - Faulty Equipment
  - Non-Patient Event
  - Security Violation
What is Considered a Reportable Patient Incident?

• Any event that is not consistent with the routine care of the patient, including near misses, or any event that causes or MAY cause patient harm or a reduction in the quality of care that we provide.

• Anything that happens to a patient that you would consider to be a deviation from Generally Accepted Performance Standards. (GAPs)

• Anything that occurs to a patient that makes you question whether or not to report it.
When to Complete a Visitor/Security Incident Report
How to Complete a Patient or Security Incident- IRIS

• IRIS= Incident Reporting Information System
  - Accessed through the intranet site, 24/7
  - Can be anonymous
  - Takes 3-7 minutes to complete
  - Top events= Falls, Medication errors, Lab Errors (Mislabeled specimen).

• We want to know:
  - Not a punitive process
  - We all make mistakes
  - Cannot change what happened but MAY be able to keep it from happening to someone else.
  - Every IRIS report reviewed by Risk Management and forwarded to the appropriate leader for F/U.
OUR GOAL?

Targeting Zero Harm by 2020
Pain Management Policy

- Patients have the right to receive appropriate assessment and management of pain.
- Pain is managed using an individualized approach considering cultural and personal beliefs and values.
The patient has a right to:

A safe environment free from abuse and harassment
What is Abuse?

**Abuse:**
The infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.

**Neglect:**
Deprivation of services by a caretaker that are necessary to maintain health or self-neglect.
Abuse of Adults and Children

Kentucky state law provides protection of adults and children who may be suffering from abuse, neglect, or exploitation.

Perpetrator could be family, care providers, agency staff or team members.

If you suspect: Report it immediately
**Our Responsibility**

**ANY** suspected cases of abuse **must be reported to your manager or charge person immediately**

Licensed health care professionals may be fined for failure to report
The patient has a right to:

- Be free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
Restraints

- Restraints should be used as a last resort!
- Minimal level of restraints should be used!
- Minimal duration!
- Read your policy! Know monitoring procedures!
How to access the Ethics Committee

• Any patient, family member, health professional, or concerned individual, may request that the Ethics Committee consider ethical questions or issues relating to health care.

• A request for consultation may be made through:
  – Medical Staff Office at each facility
  – Ethics at work hotline: 1-800-261-5607
  – In case of an emergency, the on-call ethics committee may be requested at, 587-4011
  – www.ethicspoint.com
  – Meetings of the Ethics Committee are confidential
Concerns?

Patients, team members, or other individuals may communicate concerns about quality of care or safety within KentuckyOne Health to:

- The Kentucky Cabinet for Health and Family Services by contacting the Office of Inspector General at 502-595-4079

- The Joint Commission on the Accreditation of Healthcare Organizations at 800-944-6610 or email at complaint@jcaho.org

*KentuckyOne Health will take NO disciplinary or punitive action against care providers for communicating/reporting concerns*
**Expectations and Techniques**

**Expectation: Clear & Complete Communications**
I am responsible for professional, accurate, clear and timely verbal, written, and electronic communication.

**Techniques:**
- Include the “5Ps” as part of standardized structured hand-off process when transferring & sharing patient care or other work responsibilities (Patient/Project, Plan, Purpose, Problems, Precautions)
- Use SBAR to communicate issues or concerns requiring action (Situation, Background, Assessment, Recommendation)
- Use Repeat-Backs and Read-Backs with 1 or 2 Clarifying Questions
- Document legibly and accurately

**Expectation: Personal, Patient & Team Safety**
I will demonstrate an open, personal and team (100%) commitment to safety.

**Technique: Practice Team**
**Member Checking and Team**
**Member Coaching** using ARCC (Ask a question, Request a change, voice a Concern, Invoke Chain of Command)

**Expectation: Have A Questioning Attitude**
I will “think it through,” and ensure that my actions are the best.

**Technique: Stop and resolve** when questions arise (Validate & Verify)

**Expectation: Pay Attention To Detail**
I focus on the details at hand to avoid unintended errors.

**Technique: Practice Self-Checking**
with STAR (Stop, Think, Act, Review)

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questions?