Prevention of Medical Errors: Protecting Your Patients & Your Practice

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The faculty and planners of this activity have no relevant financial relationships to disclose.
The information contained herein and presented by the speakers is based upon sources believed to be accurate at the time they were referenced.

The speaker is not engaged in rendering legal or professional services other than risk management. If legal advice is required, the services of an attorney should be sought.

This document was designed for discussion purposes only and is not intended to present detailed information on our analysis and findings. It is incomplete and not intended to be used without the accompanying oral presentation.
Learning Objectives

By reviewing the key risk issues related to medical errors, this presentation will support your ability to:

• Assess your practice for risk management issues that contribute to quality of care violations
• Identify risk management issues that contribute to diagnostic errors
• Apply risk management best practices to reduce the potential for medical errors and to improve patient safety, including the most misdiagnosed conditions determined by the Florida Board of Medicine
• Evaluate sentinel events through root cause analysis
• Evaluate your own practice risk exposures
According to the Institute of Medicine study, *To Err is Human*, published in 1999:

> At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals every year as a result of medical errors that could have been prevented…”

The report defined a medical error as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.”

According to a new study from the *Journal of Patient Safety*, published in 2013:

> [F]our times as many people die from preventable medical errors than we thought, as many as 440,000 a year.

Most Common Basis for Quality of Care Violations

WRONG SITE/
WRONG PROCEDURE
SURGERY!!!
456.072  **Grounds for discipline; penalties; enforcement.**—(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(bb) Performing or attempting to perform health care services on the **wrong patient**, a **wrong-site procedure**, a **wrong procedure**, or an **unauthorized procedure** or a procedure that is **medically unnecessary** or otherwise **unrelated to** the patient’s **diagnosis or medical condition**. For the purposes of this paragraph, performing or attempting to perform health care services **includes the preparation of the patient**.
Pause Rule

64B8-9.007 Standards of Practice. The Board of Medicine interprets the standard of care requirement of Section 458.331(1)(t), F.S., and the delegation of duties restrictions of Section 458.331(1)(w), F.S., with regard to surgery as follows:

(2) This rule is intended to prevent wrong site, wrong side, wrong patient and wrong surgeries/procedures by requiring the team to pause prior to the initiation of the surgery/procedure to confirm the side, site, patient identity, and surgery/procedure.

(2)(b) Except in life-threatening emergencies requiring immediate resuscitative measures, once the patient has been prepared for the elective surgery/procedure and the team has been gathered and immediately prior to the initiation of any procedure, the team will pause and the physician(s) or physician assistant(s) performing the procedure will verbally confirm the patient’s identification, the intended procedure and the correct surgical/procedure site. The operating physician shall not make any incision or perform any surgery or procedure prior to performing this required confirmation...

...The medical record shall specifically reflect when this confirmation procedure was completed and which personnel on the team confirmed each item. This requirement for confirmation applies to physicians performing procedures either in office settings or facilities licensed pursuant to Chapter 395, F.S., and shall be in addition to any other requirements that may be required by the office or facility.

(2)(d) The provisions of paragraph (b) shall be applicable to anesthesia providers licensed pursuant to Chapter 458, F.S., prior to administering anesthesia or anesthetic agents, or performing regional blocks at any time both within or outside a surgery setting.

Root Cause Analysis Process
Root Cause Analysis (RCA)

“... a structured analytical methodology used to examine the underlying contributors to an adverse event or condition that has already occurred.”

Risk Management Handbook for Healthcare Organizations
Root Cause Analysis (RCA)

1. What happened? – What was the adverse event or near miss? *(problem)*

2. Why did it happen? - What were the causes of the event?
   a. What usually happens? *(norms)*
   b. What should have happened? *(policy)*

3. What do we do now to prevent it from happening again? *(action plan)*

4. How will we know that our actions made a difference and improved patient safety? *(tracking/measures)*
**Team** – Develop an interdisciplinary team whose core members have multiple skills sets. Include experts from the areas being reviewed and those who are most familiar with the situation. A commitment to the RCA process and team training are necessary.

**Gather Information** – Assemble relevant facts, documentation, interviews, clinical literature and data for similar events.

**Investigation** – Flowchart or mapping of events as they occurred versus how they should have occurred.

**Identification of Root Causes** – This involves asking “why?” repeatedly at each level of cause and effect.

**Action Plan** – Recommendations are developed to prevent recurrence or to mitigate the harm in the event of future similar events. They must be implemented across the organization, rather than focusing on an individual issue or unit. Include means of measuring outcomes.
• Includes **participants with various backgrounds** associated with the systems and processes being reviewed and key leadership of the organization.
• Assures that the participants are **adequately trained** in the RCA process.
• Demonstrates internal **consistency**.
• Considers **all relevant systems & processes** involved in the event. Do not ignore the potential impact of a process on the event.
• Reviews **relevant literature** and **available data**.
RCA Process - Thorough

- Identify **human** and other factors.
- Consider all **related systems** and processes.
- Analyze through a series of “**why**?” questions.
- Identify each **risk** and how it may have **contributed** to the event.
- Focus on **potential to improve** the system through development of a **Corrective Action Plan**.
- **Communicate** and **implement** recommendations arising out of the plan.
- **Assign responsibility** to specific individuals and include desired **outcome measures**.
Root Cause Analysis – Successful Implementation

Specific
Measurable
Accountability
Reports
Timeframes
Most Misdiagnosed Conditions in Florida

- Cancer
- Neurological Conditions
- Cardiac Conditions
- Timely Diagnosis of Surgical Complications
- Urological Conditions

The majority of events have multiple root causes.

Joint Commission on Root Causes of Sentinel Events

The Joint Commission: Commonly Identified Root Cause Categories and Subcategories

**Assessment** Adequacy, timing, or scope of; assessment; pediatric, psychiatric, alcohol/drug, and/or abuse/neglect assessments; patient observation; clinical laboratory testing; care decisions

**Communication** Oral, written, electronic, among staff, with/among physicians, with administration, with patient or family

**Human Factors** Staffing levels, staffing skill mix, staff orientation, in-service education, competency assessment, staff supervision, resident supervision, medical staff credentialing/privileging, medical staff peer review, other (e.g., rushing, fatigue, distraction, complacency, bias)

**Leadership** Organizational planning, organizational culture, community relations, service availability, priority setting, resource allocation, complaint resolution, leadership collaboration, standardization (e.g., clinical practice guidelines), directing department/services, integration of services, inadequate policies and procedures, non-compliance with policies and procedures, performance improvement, medical staff organization, nursing leadership

Hand-offs
Why study hand-offs?

Sentinel Events Reviewed by The Joint Commission 2004 through 2014 (N=7804)

Communication Errors in 4,988 reported sentinel events.

Why study hand-offs?

“An estimated **80 percent** of serious medical errors involve **miscommunication** between caregivers when patients are transferred or handed-off.”

Joint Commission Center for Transforming Healthcare (2012)
What is a hand-off?

Hand-off
- Transferring care
- Provider to provider
- Department change

Sign-out
- Transmitting information
- Caregiver to caregiver
- Shift change
Primary Objective

Hand-off Goals

Transfer responsibility of care

Provide accurate information
Hand-off Scenarios

Provider Shift Changes

Nursing Unit/ Patient Care Unit

Physician/ Nurse Transfers

Home-based or Community-based Care

Discharge to home & PCP

ED to Inpatient Transfers

Hospitalist or Specialist

Occupational, Respiratory, or Physical Therapy

Hospital / Care Facility Transfers

Patient’s Continuum of Care
Hand-off Risks

“[F]or anyone who has watched children playing 'Telephone'...the inherent potential for error in signouts [hand-offs] is obvious.”
AHRQ (2012)
Case Study: Hospitalist and Specialists

Allegation: Hospitalist and orthopedic surgeons failed to diagnose an arterial injury, which led to compartment syndrome and the amputation of the patient’s leg.
Orthopedic surgeon (OS1) performed left knee arthroscopic posterior cruciate ligament. Unaware nicked left popliteal artery.

P/O Day 1 0700: Pt seen by OS2, Dx’d left foot drop and ordered ankle-foot orthosis and PT

P/O Day 1 1200: Pt seen by hospitalist. C/C severe pain, unable to wiggle toes. Arterial Doppler U/S ordered

P/O Day 2 0800: Arterial U/S indicated diminished flow in left lower leg.

P/O Day 3: Radiology informed RN venous U/S (-). RN thought Radiologist said arterial U/S (-) and advised hospitalist

P/O Day 2 cont: OS3 R/O compartment syndrome. OS3 Rx’d discharge if venous U/S (-)

P/O Day 3: Hospitalist D/C’d Pt. Pt C/C extreme pain and begged not to be D/C’d

P/O Day 4: Radiologist dictated arterial U/S report - left leg and foot not receiving adequate blood flow

P/O Day 4: Radiologist dictated arterial U/S report - left leg and foot not receiving adequate blood flow

P/O Day 7: Pt presented to ED in extreme pain and inability to move toes.
Case Study: Hospitalist and Specialists

- No one saw the initial arterial U/S report
- Second arterial U/S showed possible traumatic injury
- Emergency fasciotomy was done. Patient developed osteomyelitis, which required knee amputation
- Patient filed suit
Case Study: Hospitalist and Specialists

- Case Analysis:
  - Hospitalist should have:
    - Deferred follow-up to OS
    - Consulted with vascular surgeon
    - Communicated with orthopedic surgeons, radiologist and PCP
Case Study: Hospitalist and Specialist Risk Management Recommendations

Control H/O Communication to/from Hospitalists
- Team Leader
- Follow-up
- Post Op Care
- O/S Results

Hospitalists Stay within Scope/Comfort
- Do not practice outside of scope
- Do not practice out of comfort zone

Document
- All communication
- Consults
- Follow-up
- Send instructions to PCP

Discharge Summary
- Clear instructions to Patient
Joint Commission
Communication during hand-offs:

Use specific, descriptive language.
• NOT “She’s fine.” INSTEAD describe what it is that makes you feel the patient is improving.

Use effective communication techniques.
• Choose a location free of distractions.
• Allow an appropriate amount of time.
• Encourage and engage in interactive exchange of information.
• Clarify understanding and expectations.

Standardize reports.
• Use consistent format (e.g. checklist or script).

Joint Commission: Hand-off Process Recommendations

Establish responsibility, accountability and authority at all transitions in care.

- Ensure that providers are aware of their follow-up responsibilities

Facilitate smooth transitions between settings (e.g., from the hospital to rehabilitation, long-term care or home).

- Maintain communication with prior physician
- Ensure that discharged patients understand their instructions

Take advantage of EHR technology.

- Reconcile medication lists
- Follow up on labs
- Determine end-of-life choices
- Enter sign out lists and tasks

Allegation: *Delay in diagnosing* spinal cord compression *resulted in paraplegia.*
Case Study: Hand-offs in the Hospital

ED 4 p.m., Monday, 26 y.o. morbidly obese female pt. C/C back pain, sciatica and numbness in both legs for 2 days.

8 p.m. pt. admitted. Admissionist 1 (A1) attempted neurological exam but pt. was too impaired. A1 cut/pasted ED note into his admission note.

10:30 a.m., Pt. asks about MRI, so H1 examines pt. and schedules MRI for that afternoon. H1 also contacted Neurologist 1 (N1). Pt. had lost control of urinary and bowel function.

4:30 p.m., Radiologist 1 (R1) did not see evidence of an acute condition. He called ED physician who ordered MRI and read results. ED physician did not communicate results to others.

6 a.m., Wednesday, H2 started shift. At 9 a.m. R2 sent final MRI report to hospital.

ED Physician ordered pain medications, requested admission and ordered lumbar spine MRI next morning at an outside radiology clinic.

2 a.m., Tuesday, A1 handed off to A2. Then at 7 a.m. A2 handed off to Hospitalist 1 (H1). Based upon notes, H1 assumed pt. was offsite for MRI. He did not know that MRI was mistakenly scheduled for next day.

N1 informed H1 that he would examine pt. once MRI results were received. H1 left at 4 p.m. assuming N1 would follow pt.

5 p.m. A3 covered pt. throughout the night. Did not examine pt.

2 p.m., H2 asks N2 (on floor) to examine pt. N2 concluded that the injury was higher than lumbar spine. Ordered cervical and thoracic spine MRI.
Case Study: Hand-offs in the Hospital

- Dx: T11-12 disc herniation with compression on the spinal cord.
- Emergency surgery performed at 6:30.
- Patient never regained function of lower extremities
- Case Analysis:
  - Delayed diagnosis
  - System failure
  - Documentation failure
Case Study: Hand-offs in the Hospital
Risk Management Recommendations

Control the hand-off
- Establish primary responsibility
- Document agreement to the hand-off

Use hand-off tools
- Research the various hand-off tools available
- Adapt tools to your hospital’s needs
- Educate healthcare team members

Coordinate hand-off policies
- Bring contracting physician hand-off protocols in alignment with the hospital’s
- Ensure attending/consultant co-management responsibilities are described in protocols
- Specify how hand-offs between different services should occur

Document hand-offs
- Integrate electronic hand-off documentation into hospital EHR
- Ensure there is a permanent record of hand-off documentation
Communication Techniques
When Immediate Action is Required

**Situation**
- “I am calling about Mrs. Joseph in room 251. Chief complaint is shortness of breath of new onset.”

**Background**
- “Patient is a 62 year old post-op day one from abdominal surgery. No prior history of cardiac or lung disease.”

**Assessment**
- “Breath sounds are decreased on the right side with acknowledgement of pain. Would like to rule-out pneumothorax.”

**Recommendation**
- “I feel strongly the patient should be assessed now. Are you available to come in?”

Source: Systemic Review of Handoff Mnemonics Literature by Lee Ann Riesenber, Ph.D, RN; Jesssica Leitzsch, BS, Brian W. Little, MD, Ph.D. in American Journal of Medical Quality published online 5 March 2009 [http://ajm.sagepub.com/content/24/3/196](http://ajm.sagepub.com/content/24/3/196)
## “I PASS THE BATON”
During Transitions of Care
(i.e. shift changes, department changes, facility change)

<table>
<thead>
<tr>
<th>I</th>
<th>Introduction</th>
<th>Introduce self to patient and explain your role in his or her care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Patient</td>
<td>Name, identifiers, age, sex, location</td>
</tr>
<tr>
<td>A</td>
<td>Assessment</td>
<td>Chief complaint, vitals, symptoms, diagnosis</td>
</tr>
<tr>
<td>S</td>
<td>Situation</td>
<td>Patient’s status, code status, recent changes, responses to treatment?</td>
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<tr>
<td>S</td>
<td>Safety</td>
<td>Critical labs, allergies, socioeconomic factors, alerts (e.g., falls, isolation)</td>
</tr>
<tr>
<td>B</td>
<td>Background</td>
<td>Co-morbidities, medications, family history, previous episodes?</td>
</tr>
<tr>
<td>A</td>
<td>Actions</td>
<td>What was done and what still needs to be done, including rationale?</td>
</tr>
<tr>
<td>T</td>
<td>Timing</td>
<td>Level of urgency and explicit timing, priority of actions</td>
</tr>
<tr>
<td>O</td>
<td>Ownership</td>
<td>Who (person/team) is responsible for what aspects of care, including patient/family</td>
</tr>
<tr>
<td>N</td>
<td>Next</td>
<td>What’s happening next? Anticipated changes? What is the plan? Are there contingency plans?</td>
</tr>
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</table>
Hand-offs Between Departments and Services

- **SITUATION** - What are the names of patient and physician? What is the reason for transfer, etc.?

- **HISTORY** - What are the admitting and current diagnoses, the medical history, etc.?

- **ASSESSMENT** - What is the status of the patient’s neurological, cardiopulmonary, skin status, etc.?

- **REQUEST** - What needs to be done, e.g., labs, diagnostic studies, etc.?

- **EVALUATE** - Is there a need to inform other resources? Who?

- **DOCUMENT** - Record communications, including assessments, test results, progress notes, consultations, etc.
Diagnostic Errors
What is Diagnostic Error?

“[T]he failure to (a) establish an accurate and timely explanation of the patient’s health problem(s) or (b) communicate that explanation to the patient.”

Diagnostic Error

5% of U.S. adults who seek outpatient care
10% of patient deaths attributed to dx error
6% to 17% of adverse events in hospitals

Diagnostic Error

A frequent and expensive medical malpractice allegation

Failure to diagnose and incorrect diagnosis

$394,999 Average Indemnity

32.5% Paid-to-close ratio compared to 26% for all claims

Root Causes

System Errors
- Miscommunication
- Breakdown in Follow Up Processes
- Inadequate Supervision of Staff
- Inadequate Coordination of Care

Cognitive Errors
- Intuitive Reasoning
- Analytical Reasoning

Diagnostic Errors
Cognitive Decision Making

Intuitive

- Compare information
  - Prior disease patterns

Reflexive

- Multi-channeled
- Efficient

Analytical

Thoughtful

- Consider potential diagnoses
- Hypothesis testing

Takes time

- Need to collect and weigh data
Integrating Intuitive and Analytical Thinking

Intuitive

Analytical

DIAGNOSIS
Integrating Intuitive and Analytical Thinking

Intuitive

Biases

Analytical
Common Biases

Anchoring/Premature Closing

Availability

Emotional

Representative Restraint

Satisfaction of Search
Anchoring/Premature Closure

Settling on a diagnosis early in the work-up and discounting data that do not fit
Availability Bias

Focusing on the most readily available diagnosis, even if all of the symptoms don’t fit.
Emotional Bias

Diagnostic thinking influenced by the physician’s attitude about a particular patient
Looking only for typical manifestations of an existing illness
Satification of Search Bias

Stopping the search for a definitive diagnosis after finding one explanation for the symptoms without considering comorbidities
## Risk Management Recommendations

<table>
<thead>
<tr>
<th><strong>System and Cognitive Errors</strong></th>
<th>Recognize diagnostic errors</th>
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<tbody>
<tr>
<td></td>
<td>Take a look back</td>
</tr>
<tr>
<td></td>
<td>Ensure comprehensive follow-up processes</td>
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<tr>
<td><strong>Intuitive and Analytical Thinking</strong></td>
<td>Be alert to metacognition</td>
</tr>
<tr>
<td></td>
<td>Learn to override intuitive thinking</td>
</tr>
<tr>
<td><strong>Differential Diagnosis</strong></td>
<td>Ask, “what else might this be?”</td>
</tr>
<tr>
<td><strong>Consider Alternatives</strong></td>
<td>Ask, “what is the worst possible diagnosis?”</td>
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<tr>
<td></td>
<td>Consider comorbidities or multiple disease</td>
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<td>Consider less common diagnosis</td>
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<td>Document your analysis</td>
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Risk Management Recommendations

Be Aware of Biases

Practice Time Outs

Reapproach

Utilize Clinical Guidelines
Case Study: Failure to diagnose

Allegation: PCP and Radiologist failed to diagnose breast cancer.
Case Study: Failure to diagnose

*40 y.o. Female seen by PCP C/O left breast pain, swelling, tenderness*

*Radiologist noted density in left breast and density in lymph nodes of left axilla*

*PCP Dx: Thickening in lateral area, enlarged tender lymph node of left axilla, possible mastitis*

*Rx: antibiotics and ordered mammogram and ultrasound*

*Five weeks later, Pt. returned to PCP*  

*Dx: possible fat necrosis and costochondritis*

*Told to return in six months*

*One month later, Pt. returned to PCP C/O continued paun and tenderness*

*Dx: unresolved mastitis*

*Rx: new antibiotic*

*Eight months later presented to Gynecologist C/O worsening symptoms*

*Mammogram suspected carcinoma. Confirmed by biopsy.*

*Pt. underwent left mastectomy*

*7 of 12 positive lymph nodes*
Expert Reviews and Biases

Expert Reviewers
- Radiologist
- PCP

Diagnostic Error
- Anchoring
- Context
Risk Management Recommendations

- Bias Awareness
- Review Clinical Data
- Pursue Ultimate Dx
- Obtain Second Opinions
Case Study: Failure to diagnose in Emergency Department

41 y.o. PA presented to ED C/O thunderclap headache, 9/10 on pain scale, with nausea and photophobia

Hx: migraines, increased frequency and severity over past month

**ED Phys.** Differential dx. Included; migraine, tension headache, non-ruptured aneurysm and subarachnoid hemorrhage

Ordered CT which showed no evidence of subarachnoid hemorrhage

**Radiologist** noted area of hypodensity in rt. centrum semiovale. Recommended MRI

**Next day, Pt.** suffered extensive SAH

Pain medication reduced pain to 2/10. Based on CT results and reduced pain, **ED Phys. discharged Pt.** with Rx for hydrocodone
Expert Reviews and Biases

- ED Physician
- Anchoring
- Failing to utilize guidelines
Diagnostic Error Claims
Against Surgical Specialties
# Top Five Associated Issues in Surgical Specialty Diagnostic Error Claims

<table>
<thead>
<tr>
<th>Top Five Associated Issues – Diagnostic Error Claims Against Surgical Specialties</th>
<th>% of claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problems with history/exam/work-up</td>
<td>32%</td>
</tr>
<tr>
<td>2. Communication problems between HC providers</td>
<td>12%</td>
</tr>
<tr>
<td>3. Unnecessary treatment</td>
<td>9%</td>
</tr>
<tr>
<td>4. X-ray error</td>
<td>9%</td>
</tr>
<tr>
<td>5. Failure to follow up</td>
<td>8%</td>
</tr>
</tbody>
</table>

NORCAL Companies Claims  Data 1/1/2010 - 12/31/2014
Incident Location – Surgical Specialty Claims

- Hospital: 45%
- Practitioner's Office: 46%
- Outpatient Facility: 5%
- Surgicenter: 2%
- Other: 2%

NORCAL Companies Claims Data 1/1/2010 - 12/31/2014
Risk Management Recommendations – Surgical Specialties

- Be Aware of Biases
- Establish Differential List
- Follow-up System
- Document Thoroughly
Risk Management Recommendations – Surgical Specialties

- Effective Handoffs
- Coordinate Referrals
- Seek Additional Evaluation
- Discharge Instructions
Improve Clinical Reasoning, Reduce Errors and Foster Diagnostic Accuracy
IOM Goals for Improvement

- Facilitate more effective teamwork
- Enhance education and training
- Ensure health IT supports the process
- Develop approaches to collect information on diagnostic error and near misses
IOM Goals for Improvement

- Establish a culture that supports improvement
- Develop a system that facilitates improvement
- Design care delivery and payment environments that support the diagnostic process
- Provide dedicated research funding
Risk Management Recommendations

Diagnostic Time-Outs

Seek Additional Information

Patient Education

Utilize Clinical Guidelines
Risk Management Recommendations

- Seek Diagnostic Error Rates
- Consider Checklists
- Use EHR Tools
- Evaluate Personal Stresses
Risk Management Recommendations

Consider Ongoing Symptoms ➔ Consider Limits of Studies
In Summary

- Address System Errors
- Address Cognitive Errors
- Mitigate Biases
Failure Mode & Effect Analysis (FMEA)

1. Function or Process Step
2. Failure Type
3. Potential Impact
4. Severity
5. Potential Causes
6. Occurrence Frequency
7. Detection Mode
Failure Mode & Effect Analysis (FMEA)

8. Risk Priority
9. Recommended Actions
10. Responsibility Assignment
11. Target Date for Recommended Actions
12. Action Taken
13. Reassess Risk Priority, Severity, Occurrence, Detection Modes
Role of Medical Office Staff in Risk Management & Patient Safety
Identify Patients Correctly

• Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

• Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Use Medicines Safely

• Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

• Take extra care with patients who take medicines to thin their blood.

• Record and pass along correct information about a patient’s medicines.

Use Medicines Safely cont.

• Find out what medication the patient is taking.
• Compare those medicines to new medicines given to the patient.
• Make sure the patient knows which medicines to take when they are at home.
• Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

2016 Ambulatory Care National Patient Safety Goals

Prevent Infection

• Use the hand cleaning guidelines from the CDC or the WHO. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

• Use proven guidelines to prevent infection after surgery.

Prevent Mistakes in Surgery

- Make sure that the **correct surgery** is done on the correct patient and at the **correct place** on the patient’s body.

- **Mark the correct place** on the patient’s body where the surgery is to be done.

- **Pause** before the surgery to make sure that a mistake is not being made.

How can you & your staff contribute to patient safety and reducing risk?
### Little things mean a lot!

#### EXCELLENT CUSTOMER SERVICE

- Greetings & acknowledgments
- Smiles & facial expressions
- Helpful gestures (holding doors, helping with kids, wheelchairs...)

#### COMMUNICATION

- Eye contact
- Watch for non-verbal cues – nods, smiles...
- Listening behaviors – repeating back names, etc.

#### PERCEPTION/ATTITUDE

- Concern & compassion
- The extra step
What can your staff observe about your patients and their circumstances that might help the providers in caring for them?
  • Lifestyle/Culture
  • Language abilities

Ask, “Have the appropriate educational materials been provided?”
Q & A
Thank You!
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