



Conversations in Patient Safety

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Thank You!!



Patient Safety Topic Areas

- *Medication safety*
- *Medical complications*
- *Communication
Improvement*
- *Human factors
engineering*
- *Culture of safety*
- *Technology approaches*



Topics you would like to discuss

Global

- Implementing 2007 NPSG
- How to monitor and audit compliance and NPSG; sharing of best practices
- Institute for Healthcare Improvement 5 Million Lives Campaign

2007
National Patient Safety Goals



An Introduction to the
5 Million Lives Campaign

December 12, 2006



Topics to discuss – medication

- Medication reconciliation involving transfers into/out of CCUs
- Medication safety; patient involvement
- Medication reconciliation from hospital to LTC facility to home



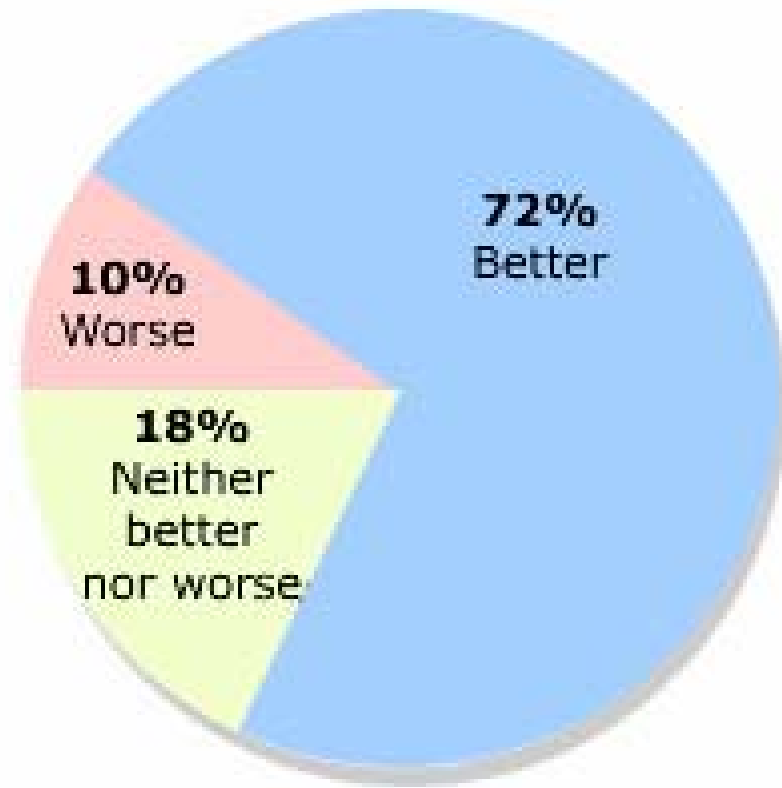
Topics to discuss – across settings

- Patient safety in a physician office settings and continuity of care when transitioning from one setting to another
- Communication
- DVT prophylaxis



What we see...

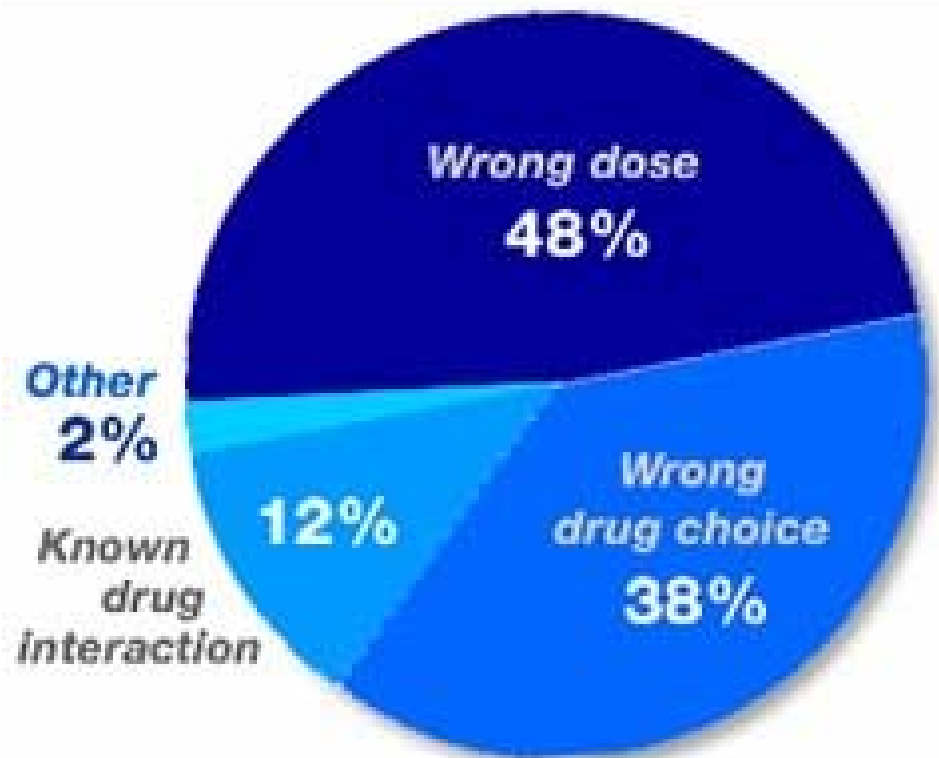
Nurses' perceptions of overall medication safety in their hospital since the IOM report





Extended care....

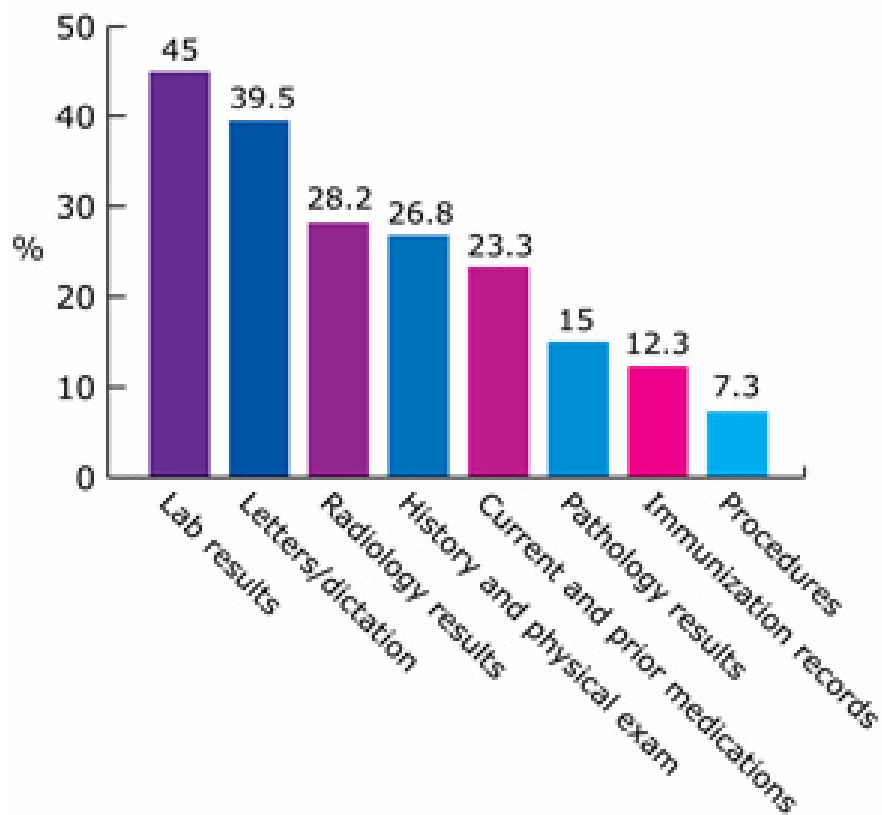
Most common prescribing errors in long-term care facilities



Everyday office care...



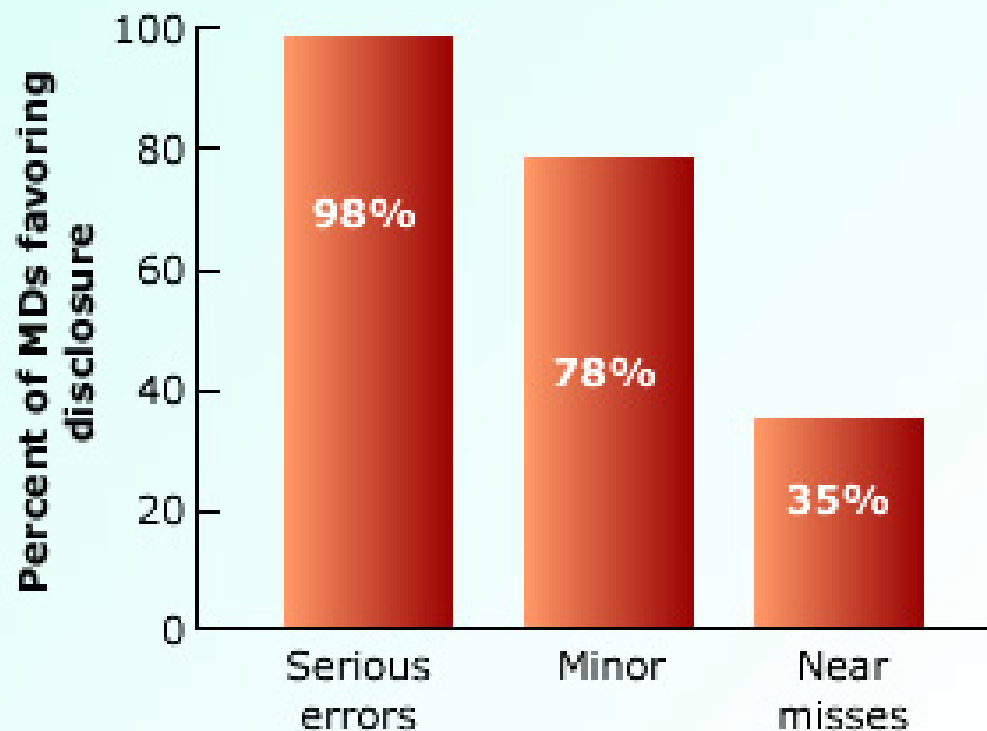
Categories of missing clinical information during primary care visits





What we think should occur...

Most physicians think serious and minor errors should be disclosed





Case Study

An infant receives an overdose of the wrong antibiotic (cephazolin instead of ceftriaxone). The nurse spoke with the ED physician on duty but was informed that the medications were essentially equivalent and did not report the error.





Strategies to Improve Incident Reporting

- Promote and sustain a culture of learning from mistakes.
- Make incident reporting an individual performance expectation.
- Have clear definitions for reportable events that everyone understands.
- Make it easy to report and provide several different reporting methods.
- Allow for anonymous error reporting.
- Maintain a confidential incident reporting system.
- Use reports to identify common error-producing factors, not just to create incident counts.
- Share the learning derived from incident analyses with physicians and staff.
- Communicate and celebrate improvements that result from analyzing reported events.



Attitudes and Climate of Safety

- Safety Survey tools
(University of Texas)
 - Available for various settings including ambulatory
 - http://www.uth.tmc.edu/schools/med/i-med/patient_safety/survey&tools.htm



The Medication Reconciliation Process Flow Chart

