

WINSTON RESOURCES, LLC
WINSTON MEDICAL STAFFING SERVICES

WHAT EVERY EMPLOYEE SHOULD KNOW & DO TO INCREASE SAFETY

2009 NATIONAL PATIENT SAFETY GOALS

Adapted from the 2009 JCAHO Guidelines

• IMPROVE ACCURACY OF PATIENT IDENTIFICATION

Use at least 2 patient identifiers (neither to be patient's room#) whenever administering medications or blood products, taking blood samples/other specimens for clinical testing, or providing other treatments/procedures.

• IMPROVE EFFECTIVENESS OF COMMUNICATION AMONG CARE GIVERS

Implement "read-back" of complete order when taking verbal/telephone orders/receiving critical test results. Standardize abbreviations, include a "DO NOT USE LIST." Improve timeliness of reporting and receipt by caregiver of critical test results and values.

• IMPROVE SAFETY OF USING HIGH-ALERT MEDICATIONS

Remove concentrated electrolytes from patient care areas; Use Cautions with Heparin & Insulin. Standardize and limit number of drug concentrations. Annually review a list of look-alike/sound-alike drugs.

• ELIMINATE WRONG-SITE, WRONG-PATIENT, WRONG-PROCEDURE SURGERY

Create a pre-op verification process, such as a checklist to confirm appropriate documentation. Implement a process to mark surgical site, involving patient in process.

• IMPROVE THE EFFECTIVENESS OF CLINICAL ALARM SYSTEMS

Implement regular preventative maintenance & testing of alarm systems. Assure all alarms are activated with appropriate settings and are audible with respect to distance and competing noise.

• REDUCE THE RISK OF HEALTHCARE-ASSOCIATED INFECTIONS

Comply with current CDC hand hygiene guidelines. Manage as sentinel events all identified cases of unanticipated death/major permanent loss of function associated with healthcare-associated infection. Use safe practices to treat the part of the body where surgery was done.

• ACCURATELY & COMPLETELY RECONCILE MEDICATIONS ACROSS CONTINUUM OF CARE

Develop with patient maintain list of patient's current medications; include comparison of hospital medications administered. Communicate patient's medications to next care provider when transferring to another level of care. The complete list of medications is provided to the patient on discharge from facility.

• REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS

Assess/reassess patient's risk for falling, consider medication regimen.

• PRESSURE ULCERS

Prevent health care-associated pressure ulcers (decubitus ulcers.)

• INFLUENZA AND PNEUMOCOCCAL DISEASE

Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.

• SURGICAL FIRES

Reduce the risk of surgical fires.

• INVOLVEMENT OF PATIENTS AND FAMILIES

Encourage the active involvement of patients and their families in the patient's care as a patient safety strategy.

• THE ORGANIZATION IDENTIFIES SAFETY RISKS INHERENT IN ITS PATIENT POPULATION

The organization identifies safety risks inherent in its patient population and patients at risk for suicide.