NURSING: Making Patient Safety a Priority, every day  3/22/17

SAFE PATIENT CARE ENVIRONMENT

Daily Checklist  (Possible score 24)  Passing Score (24)
Score Achieved ___________  Pass  Fail

- No unresolved discrepancies remaining from previous shift.
- Refrigerator temperature logs Refrigerator/freezer temps are recorded every day and logs are current. Corrective action taken and resolved when temperature was not within normal limits.
- Crashcart checks have been completed.
- Blanket warmer temperature is no more than 130 degrees.
- All medications are locked or attended.
- All medications are locked or attended. (Med rooms and carts)
- No medications are seen being carried in employee pockets.
- Medications/syringes are labeled (pt name, medication name, strength, date) Multi-use vials are dated. NO vials on unit within 28 days of opening.
- There are no expired meds (anesthesia carts, EP/Cath Lab).
- There are no unlabelled or outdated food in patient food refrigerators.
- There are no unsecured lab specimens at desk (must be labeled and sealed in plastic bag for transport).
- Isolation signs are present where applicable; isolation set-up is correct. (Survey all isolation rooms on the unit)
- Food and Drink: There is an area at the nurse's station or other location which is separated from work areas subject to contamination and is so situated that it is not reasonable under the circumstances to anticipate that occupational exposure through the contamination of food and beverages or their containers is likely.
- Identify a physician on the unit. Staff to identify how they validate the physician is credentialed to provide care / do a procedure.
- Hallways have a clearance of 8 feet.
- No storage of anything in corridor, unattended for more than 15 minutes. Isolation carts and code carts are the only exception.
- Gas cylinder are chained in protective cages. Oxygen tanks are stored in racks. No more than 12 gas cylinders in a location.
- Clean utility room has only CLEAN items.
- Soiled utility has only DIRTY items.
- No linen on the floor.
- Linens are always bagged when exiting the patient's room.
- All linen and supply carts have a solid bottom shelf.
- Complete an inspection of an unoccupied patient room and bathroom. Both are clean and there is no previous pt equipment in room.
- Area is not cluttered and tidy.

INFECTION CONTROL

Daily Checklist  (Possible score 1)  Passing Score (1)
Score Achieved ___________  Pass  Fail

- Hand Hygiene. All staff, including physicians, foam in and out of all patient rooms.
- MDRO education is completed on all patients with MDROs.

RESTRAINT USE: Assess every pt in restraints on the unit

Daily Checklist  (Possible score 1)  Passing Score (1)
Score Achieved ___________  Pass  Fail

- Restraint elements met at 100%?

ASSESSMENT

Weekly Checklist  (Possible score 2)  Passing Score (2)
Score Achieved ___________  Pass  Fail

- What is the time frame for assessment of the patient when he/she arrives to the unit? Answers will vary depending on the unit.
- Patients are reassessed each shift and when there are significant changes to the patient's condition.
The patient was admitted for hysterectomy and will receive the first dose of a new medication.

**Example:** The patient was admitted for hysterectomy and will receive the first dose of a new medication.

- **What are the top 3 concerns for this patient?** The top 3 concerns are pain management, genitourinary, and patient education of new medication.
- **How do you revise the plan of care?** We update and revise the care plan each shift—validate there is documentation in EHR.
- **How do other disciplines know?** Any discipline can access the care plan to see what important issues we are focusing on.

<table>
<thead>
<tr>
<th>Number of Element Met</th>
<th>Number of Care Plans Assessed</th>
<th>% Compliant (Passing score 94%)</th>
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**MEDICATIONS / PAIN / CRITICAL VALUES / HANDOFF**

- **Before Medication is administered.** Staff complete patient identification: Staff ask patients to state their name and birth date and compare with armband.
- **Staff describe that pain is assessed on admission or each visit.** (Include ED, Sleep, Pain Clinic, Cardiac Rehab, Rehab). Pain is reevaluated each shift.
- **The effectiveness of pain interventions** is regularly reassessed after interventions, medications. Validate in the EHR.
- **Read Back Critical Values:** The receiver of the information:
  - First, writes down the test result received.
  - Then, reads back the test result.
  - Notify the physician within 60 minutes. Document dr is notified.

**SURGICAL/INVASIVE PROCEDURES**

- Physician documents informed consent in H&P or progress note.
- Hospital verifies informed consent is obtained prior to procedure.
- H&P is appropriate. If not, the patient is not taken to surgery.
- If a H&P is completed 30 days prior to the procedure, a history and physical is updated, noting any changes within 24hrs.
- **Universal Protocol:** A time-out is performed immediately prior to starting procedures. Everyone, including anesthesia SUSPENDS all activities. (Including drawing up antibiotics). All verbally acknowledge agreement.
- During time-out, at least one member of the team verified the patient’s identity by double-checking the patient’s name on the chart with the wrist band.
- Postoperative progress note is done immediately and contains all essential elements.
- **Patient Identification:** Containers used for blood and other specimens are labeled in the presence of the patient.
- There are no pre-labeled syringes. Are all the syringes labeled and initialed?
- All syringes and open containers of fluid are labeled (Cath Lab, OR).
- Fluid transferred from an original container is labeled.

**PERFORMANCE IMPROVEMENT**

- **Staff show scorecard and identify Quality Improvement (Patient Satisfaction, VAP, Falls, MRSA, Central Line Infection Reduction).**
- **What do I do in the event of CODE RED, fire, smoke?**
  - **Staff describe RACE**
    - Rescue anyone in immediate danger
    - Alarm (pull the alarm)
    - Contain the fire by closing doors
    - Extinguish the fire, if possible, or evacuate, if ordered
  - **Staff describe how to use a fire extinguisher?**
    - Pull the pin
    - Aim at the base of the fire
    - Squeeze the handle
    - Sweep the spray across the fire – side to side
  - **Staff show the surveyor where the closest extinguisher is**
  - **Staff show the surveyor the closest pull box**, it is easily visible and unobstructed.
  - There is 20” clearance from the ceiling.
  - Electrical equipment that patient brings is inspected by nursing staff. If no frayed cord and visually operable, then it may be used.
  - **No smoke or fire doors are propped open.**
  - **Emergency exit signs** are illuminated & consistent with egress. **EXIT SIGNS are the means/way of egress!**
  - How do I evacuate patients-to separate pts from smoke or fire?
  - Move patients and staff to the next closest smoke compartment on the same floor. Horizontal evacuation is the 1st choice!
  - **Staff identify the smoke barrier locations**

**MEDICAL GAS SHUTOFFS/STORAGE OF GASES**

- Staff describe only designated staff may turn off the gas. Who may turn it off is posted by the gas shut off valve. Staff locate gas shutoff

**CEILINGS/DUST**

- Ceilings are free of any damage, water marks, loose grid work, loose tile, loose light fixtures or light lenses that may cause injury
- **No lint accumulations or evidence of soiled conditions** on ceiling mounted devices such as but not limited to grills, light lenses, sprinkler heads, smoke detectors

**Working with chemicals**

- **Cleaning Products** are labeled with product name & hazard warning
- **Staff verbalize MSDS** (Material Safety Data Sheets) are used to provide information needed to allow the safe handling of hazardous substances
- **Housekeeping carts** are attended/no chemicals are accessible