Ten Tips to Help Promote Patient Safety

September 21, 2016

The American Society for Healthcare Risk Management (ASHRM) is the leading society for health care risk managers. The organization believes that all health care workers hold the opportunity to be guardians of patient safety.

The following are suggested practices, based on information published by ASHRM, that can help eliminate or minimize serious safety events. They are not standards of care, but likely represent best practices to promote patient safety in the hospital setting:

1) Adverse Drug Events

According to the Institute for Healthcare Improvement (IHI) high-alert medications include:

- Anticoagulants
- Opioids
- Sedatives (including benzodiazepines, muscle relaxants and sleep agents)
- Insulin These medications, due to their high volume of use, coupled with their inherent risks, are responsible for the majority of harm due to all high-alert medications. Techniques to reduce patient safety risks with these agents include mandatory read-backs, independent duplicate dose calculation, standardized solu-tions, patient education and empowerment, close monitoring and careful patient selection of the least toxic (but therapeutic)

agent.

2) Catheter-Associated Urinary Tract Infections (CAUTI) Among the 10 hospital-acquired conditions selected by the Centers for Medicare & Medicaid Services, CAUTIs received a top priority due to their high cost and high volume, and because it can be reasonably prevented through application of accepted, evidence-based prevention guidelines. To help prevent CAUTI, you should:

- Always clean your hands before and after doing catheter care.
- Not tug or pull on the tubing.
- Not twist or kink the catheter tubing.
- Assess the need for the catheter frequently and discontinue it as soon as appropriate.

3) Central Line-Associated Blook Stream Infections (CLABSI) According to the Hospital Engagement Network's website, CLABSIs result in 84,551 to 203,916 pre-ventable infections and 10,426 to 25,145 preventable deaths annually. As stated in the Centers for Dis-ease Control (CDC) and Prevention's Guidelines for the Prevention of Intravascular Catheter-Related Infections, well-organized programs that enable health care providers to become educated and to pro-vide, monitor, and evaluate care are critical to the success of this effort in helping to prevent CLABSI. To decrease the risk of CLABSI, you should:

- Clean the patient's skin with an antiseptic cleaner before inserting the central line. Also wear a mask, cap, gown and gloves when putting in the line to keep it sterile. The patient should be covered with a sterile sheet.
- Before using the line to draw blood or give medications, wash your hands, wear gloves and clean the central line opening with an antiseptic solution.
- Evaluate daily if a patient still needs the central line and remove it as soon as it is not needed. These straightforward practices can greatly reduce CLABSIs, but only if there is near 100 percent compliance of the health care team.

4) Patient Falls In hospitals and other health care facilities, patient falls are among the most frequently reported incidents. Unlike some other types of adverse events, many inpatient falls cause little or no harm, but the high overall rate of falls means that they are a significant cause of hospital acquired injury. To help prevent patient falls, you should:

- Be aware of medications that affect the central nervous system.
- Pay attention to bathtubs and toilets without grab bars, poor lighting, and improper use of bedside rails and other mechanical restraining devices.
- Communicate the patient's risk of falling to all staff, the patient and the patient's family. Again, near 100 percent compliance is optimal; the one time the at-risk patient is assumed to be "safe" can be the time a serious fall occurs.

5) Obstetrical Adverse Events According to the Institute for Healthcare Improvement (IHI), in the U.S. there are more than four million births each year. Although many births may seem uneventful and normal, opportunities to reduce potentially preventable harm to mother and baby are relatively frequent. To reduce the risk of obstetrical adverse events, you should:

- Revisit orientation and training processes, communication protocols and competency assessments, and determine if they are being implemented properly.
- Provide physician education and counseling.
- Reinforce chain-of-communication policy.
- Utilize in-situation simulation where available.

6) Pressure Ulcers Between 1 and 3 million people in the U.S. develop a hospital acquired pressure ulcer (HAPU) every year. Hospital acquired pressure ulcers reduce overall quality of life due to pain, treatments and increased length

of institutional stay, and may also contribute to premature mortality in some patients. A few ways to reduce the occurrence of pressure ulcers include:

- Conduct skin/risk assessment and reassessment.
- Manage moisture.
- Optimize hydration and nutrition.

7) Surgical Site Infections (SSI) In a 2009 study, the Centers for Disease Control and Prevention (CDC) found that more than 110,000 SSIs occurred among patients undergoing one of 17 major operations that were selected for the research. Did you know that the majority of SSIs are largely preventable, and evidence-based strategies have been available for over 10 years and implemented in many hospitals. Worldwide attention to safer surgery, including prevention of SSIs, led to the development of the World Health Organization Surgical Safety Checklist which demonstrates the importance of teamwork and communication in preventing SSIs.

8) Ventilator-Associated Pneumonia (VAP) The Institute for Healthcare Improvement (IHI) defines VAP as pneumonia occurring more than 48 hours after a patient has been intubated and received mechanical ventilation, and is caused when microorganisms invade the lower respiratory tract and lung parenchyma. Implementing the ventilator bundle can reduce the risk of these complications and the occurrence of VAP. The VAP prevention bundle includes:

- Head of bed elevated between 30 to 45 degrees.
- Oral care with chlorhexidine 0.12 percent.
- Peptic ulcer prophylaxis.

9) Venouse Thromboembolism (VTE) VTE is the most common cause of hospital death and is identified as a blood clot (thrombus) that forms within a vein. Thrombosis can occur when blood flow within the veins is slowed or blocked, the lining of the vessel wall is damaged (due to surgery or injury), or too many blood-clotting substances are present in the blood. Risk factors for VTEs are especially high for individuals who have experienced:

- Major general surgery.
- Major orthopedic surgery.
- A spinal cord injury. While the risk/benefit assessment for VTE prophylaxis is unique to every patient and their procedure or condition; a systematic and documented risk assessment is critical to the defense of the case when either the patient suffers a VTE from alleged under-prophylaxis or a bleed due to the known complication rate of the prophylactic regimen.

10) Preventable Readmissions A 2009 study published in the New England Journal of Medicine demonstrated that almost one-fifth (19.6 percent) of Medicare patients were readmitted to the hospital within 30 days of discharge, and 34 percent were readmitted within 90 days. In a 2009 survey of 107 hospitals and health plans, the finding revealed these top strategies to prevent hospital readmissions:

- Case management (66 percent of respondents).
- Care transitions management (62 percent).
- Telephone monitoring post-discharge (56 percent).

Sources: 1) Institute for Healthcare Improvement 2) Centers for Disease Control and Prevention 3) Centers for Disease Control and Prevention 4) Preventing Patient Falls, Joint Commission Resources 5) Sentinel Event Alert, Issue 30: Preventing infant death and injury during delivery. The Joint commission 6) Cynosure Health 7) Institute for Healthcare Improvement 8) Hospital Engagement Network 9) The American Heart Association: Four Topics in Venous Thromboembolism—Risk Factors for Venous Thromboembolism 10) Benchmarks in Reducing Hospital Readmissions. Sea Girt, NJ: Healthcare Intelligence Network, Feb. 2010

Created by MagMutual from materials provided by COPIC as part of MagMutual and COPIC's alliance to improve patient safety and quality of care for all of our PolicyOwners.