Patient Safety Report for the 2nd Quarter of 2014
Department of Patient Safety

Executive Summary:

A- Hospital wide Patient Safety Report:

SUNY- Downstate Medical Center University Hospital at Brooklyn has a Patient Safety Committee by the representation of leadership to frontline staff. The committee is chaired by the Director of Patient Safety (Patient Safety Officer). The Director of Patient Safety gives the strategic oversight and implementation expectations of Patient Safety Plan with an interdisciplinary collaboration. The program is overseen by the Chief Medical Officer (Medical Director).

From January 1 of 2014 The National Patient Safety Goals are in effect including the new National Patient Safety Goal 06.01.01-“Reduce Patient harm and improve the Clinical Alarm system”.

In the second quarter of 2014, the rate of compliance for all the National Patient Safety Goals is measured and is attached to this report. This is an ongoing process evaluation. We have steady and positive progression to achieve our goal for full compliance in all the care giving areas on the National Patient Safety Goals. There is ongoing communication on any patient safety issues with the staff members. The chief residents, rotating residents, program directors, DIO, Nursing Staff, Coordinators from ancillary areas, hospital administrators from different services are actively participating in the Patient Safety meetings. A monthly report is provided to the Patient Safety Committee, the Departmental P.I. committees and the Medical Executive Committee. The quarterly report is provided to the Executive Improvement Council and the Governing Body.

B- Hospital wide ongoing Patient Safety Programs in 2014:

1. **Patient Identification ad-hoc committee** is working on the multiple improvement projects to develop and sustain the safe patient identification process, such as :
   a. Ongoing monitoring by direct observation technique, concurrent and retrospective medical record review for the full compliance of Patient Identification process
   b. Staff education and acknowledgement to establish the responsibility and accountability **through the managerial oversight** by each clinical care areas (i.e., Radiology, CT scan/ MRI, Radiation Oncology, ER, Nursing Units, all Registration areas, etc). Monthly Patient Identification Report from the respective units to the Departmental P.I and Patient Safety Committee. The Director of Patient Safety also conducts a year round bi-weekly employee orientation program on patient safety practices that includes “Patient Identification” process.
c. Correct patient with the correct order for any diagnostic procedure should be double checked by the ordering
clinician or their designated staff. Prior to administration of any medication the patient identification must take place.

d. Addressing the necessity for **overall Bar-coding for patient identification**, Bar-coded label in patient’s chart,
electronic OR reservation form, etc.

The HealthBridge CPOE system has implemented Knowledge Based Medication Administration Bar-coding
system on September 7, 2014 in NS 33, 61 & 82. The complete roll out program is forthcoming. It is
designed to provide patient safety features during medication administration – ‘with the barcoding
mechanism an electronic check step is established’.

Application Usage:

At the bedside, nurses will use hand held devices to scan barcodes on the medication packets and the patient’s
armband to verify the five rights of medication administration: **right patient, right medication, right time, right
dose and right route**.

If these rights are not met, an alert is triggered in Healthbridge prompting the nurse to check the patient's charts
and the doctor's orders.

If all rights are met, the dose is administered and the patient’s electronic medication administration record is
automatically updated.

e. The blood transfusion committee and blood bank are reporting on the mislabeling of the blood specimen tube
(WBIT). The percentage of incidence in SUNY-Downstate (1:1800) is lower than the national bench mark (1:1000).
The process review for further improvement is underway.

**2. Timely reporting of critical results** is in practice for the laboratory test result reporting, cardiology test result reporting,
radiology result reporting. Intervention report with the outliers is published monthly. In some of the cases it was found that
the lab technician is kept on hold by the units during the communication with the critical results.

The department of patient safety is monitoring the performance of ‘DO NOT ABBREVIATION LIST’. We still have
challenges to overcome with not to write “QD, qd, U and u” on medication order form, medication reconciliation list and in
the medical record. With the implementation of CPOE Medication Management module medication orders cannot be
prescribed with the unauthorized abbreviations. But in the different sections of paper based medical record still have some
QD and U (in the internal medicine progress notes, medication reconciliation form, progress notes, etc). The non-
compliance report is shared with the program directors to educate the residents to avoid unauthorized abbreviations in any part of the medical records.

3. **Medication Safety practice** monitoring is ongoing on the issues related to Medication Management. Some of the identified safety highlights are described as follows:
   a. In the inpatient units medication carts are identified with the discharged patient’s medication that is found in the active patient’s medication cart.
   b. Some of the Intravenous Diluent bags were found without label and patient’s identification. **During administration of a medication it is essential to identify the patient against the dispensed medication and its dosage. There can be a scenario of a same drug is ordered for multiple patients with same dose.**
   c. A new format of ongoing Medication Error Report for the prescribing part in CPOE has been published since the second quarter of 2012. The report is ongoing as quarterly basis. The significant highlights are the improper dosing, missing allergy history of the patient, missing/ incomplete medication reconciliation with the admitting medication orders; in some cases the heights and weights were missing or were not interfaced among the systems and lack of timely receiving of medication reconciliation information for the admitting orders in pharmacy. The current CPOE system had implemented the Order Reconciliation module in the April of 2013. The ongoing process will also have to address the interfacing of T-system medication reconciliation information that has to be integrated with the admitting orders.
   
   a. Hospital wide **Anticoagulation therapy management program** is ongoing. We have an Anticoagulation therapy management guideline and protocol. We have established a baseline data collection monitoring tool. Patient Safety Committee and Pharmacy & Therapeutics Committee are the oversight of this program. Educating staff to use the protocol, collecting data on time, are the scopes for improvement that we are focusing on. Currently, we are re-evaluating the new chest guideline of 2012 in terms of managing the patient more aggressively with warfarin according to the level of their INR value. There is a recent development of the VTE prophylaxis implementation to be compliant with the new core measure set from January 2013. This program includes an electronic DVT/ VTE order set and ensures the prophylaxis by establishing a risk assessment scoring tool, adult full dose and low dose protocol to provide therapeutic regimen for anticoagulants.
   b. Collecting the blood specimen to receive the laboratory findings on aPTT and INR level timely by a nurse/ phlebotomist in a 24/7/365 basis.
   c. Changing the Heparin regimen according to the guideline by a nurse/ physician and follow through the utilization of medication by a Pharmacist. Transcription of changes should be reflected on the MAR (medication administration record).
   d. Utilizing the base line data collection monitoring tool to ensure the quality assessment part of the program by Performance Improvement Manager, Patient Safety Coordinator and Pharmacist
e. The Anticoagulation Therapy Management Team is continuously monitoring the program for its effectiveness. Department of Patient Safety is collecting the data on the anticoagulation safety and efficacy.

f. Robust patient education on their anticoagulation therapy and ensuring the process with electronic discharge information.

4. The Department of Infection Control and The Hospital Infection Control Committee is working on the staff compliances on Hand Hygiene and to reduce the risk of health care associated infections, such as, prevention of infections due to multidrug-resistant organisms in acute care hospitals, prevention of central line-associated bloodstream infections and implement evidence-based practices for preventing surgical site infections. There is ongoing monitoring for the newly implemented National Patient Safety Goal (NPSG.07.06.01) - Prevention of Catheter Associated Urinary Tract Infections (CAUTI).

5. The hospital wide identification of safety risks inherent in its patient population and “Suicidal Ideation” screening process is ongoing. The Department of Psychiatry and the Nursing are overseeing the program.

6. In our current system the medication reconciliation is completed electronically and the actual prescribing, dispensing and administration information is documented electronically in the Eclipsys medication management module.

7. The Universal Protocol applies to all surgical and non-surgical invasive procedures. The Universal Protocol is confirmed by the actual time-out process that is practiced all across, however, in some cases it was identified that the participation of all the team members are not uniform, meaning during the time-out, all participating providers must pay full attention to the process. Pre verification of the patient’s identification, marking of the correct site and side of the body and performing a time-out before the procedure is crucially important to be 100% compliant with the standard and in our practices.

It is very important to complete the Universal Protocol Form during time-out. According to the New York State guidelines for the Universal Protocol all campuses should adhere to the same policy and protocol. The OR reservation form for the patient’s procedure must be completed from the doctor’s office accurately for the correct patient with the correct side and site of the procedure.
The attached links will provide access to our current policies.

8. A multidisciplinary failure mode effect analysis (FMEA) project on “Establish Effective Communication to Provide Patient Centered Care” was started in the third quarter of 2010 and was completed in the first quarter of 2011. Risk Priorities for this proactive process were identified and continuous interdisciplinary process improvement is ongoing. The report was presented in the Patient Safety Committee meeting and the Executive Performance Improvement Council meeting of March 2011. Each of the Risk priorities was discussed in the Patient Safety Committee over the year of 2011.

9. We will be conducting the Culture of Safety Survey from the third quarter of 2014. It is a hospital wide web based survey. We adopted the AHRQ model for this culture of safety survey. We also shared the survey data with the New York State Partnership for Patient’s –Healthcare Engagement Network (NYSPFP- HEN). This is a CMS mandated project to establish an organization wide patient safety culture.

The 2012 analysis is attached in this report:

Focus points: Responses are equal in agreement and disagreement
1. Staff work longer hours
2. Management support for culture of safety
3. Feedback and communication about error is in practice
4. Sometimes things may “fall between cracks” during transferring patients across units
5. Problems may occur in cross unit communication

   a) Improvement can be made in communication across units
   b) Improvement can be made in communication at tour or shift change time
   c) Emphasizing that any proposed improvements are not meant as personal critiques but system wide implementation.

10. Product Safety Process Improvement: We implemented a Web-based Recall Management System- RASMAS in January 2010. The Product safety policy was revised in March accordingly. Continuous process monitoring and improvement is ongoing. This system gives us better opportunity to tracking and trending for our action and response in closing out an alert or recall. We used to manage only medical device as a product safety item. With the help of RASMAS, we can manage 14 categories of products (such as, Pharmaceuticals, Biologics, OR products, Medical Devices, Facilities and Environmental
products, Food and nutritional products, etc). We have product safety coordinators to manage each of the domains and an interdisciplinary group of responders are working along the coordinators. The volume of monthly recall is significantly higher than the previous system. Hospital is managing thousands of recalls a year compare to tens and hundreds. The office of Risk Management and RASMAS database has all the information. We evaluate the process and update the staff through our monthly Patient Safety Committee meeting. The Risk Management, the Product Safety sub-committee, the Patient Safety Committee, the Departmental P.I Committees, EPIC and the Medical Executive Committee are overseeing the process.
# Patient Safety Quarterly Compliance Report on NPSGs in 2014

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## NPSG Compliance Data of SUNY-DMC in 2014

<table>
<thead>
<tr>
<th>Standards</th>
<th>National Patient Safety Goals</th>
<th>Compliance rate</th>
<th>Compliance rate</th>
<th>Compliance rate</th>
<th>Compliance rate</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG. 01.01.01</td>
<td>Two patient identifiers are used to identify a patient when providing treatment, procedure</td>
<td>98% (1139/1165)</td>
<td>97% (1344/1392)</td>
<td></td>
<td></td>
<td>Two patient identifiers policy is not followed during the identification process. Direct observation at point of care, ID band matching, Photo ID matching, Documentation in MR, Blood transfusion report, collecting specimen and labeling at bed side, incorrect MR#, wrong patient’s medication orders, etc.</td>
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<tr>
<td>IM. 02.02.01</td>
<td>Avoid “Do not use” abbreviation list</td>
<td>96% (1107/1148)</td>
<td>97% (1266/1311)</td>
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<td>“QD, U” is written in the Medical Record and medication order</td>
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<tr>
<td>NPSG. 02.03.01</td>
<td>Timeliness in Reporting critical test results</td>
<td>98% (118/121)</td>
<td>98% (212/217)</td>
<td></td>
<td></td>
<td>Lab, Radiology &amp; Cardiology critical results timeliness compliance</td>
</tr>
<tr>
<td>NPSG. 03.04.01</td>
<td>Verification of medication and solutions labeling for accuracy</td>
<td>99% (110/111)</td>
<td>98% (108/110)</td>
<td></td>
<td></td>
<td>Observation in Dispensing &amp; Administering process</td>
</tr>
<tr>
<td>NPSG. 03.05.01</td>
<td>A written policy and protocol is followed for the</td>
<td>100% (265/265)</td>
<td>100% (322/322)</td>
<td></td>
<td></td>
<td>A written policy and protocol in place and anticoagulants are ordered on designated order form</td>
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<tr>
<td><strong>initiation and maintenance of anticoagulant therapy</strong></td>
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<tr>
<td>aPTT was ordered 6 hrs. after heparin initiation</td>
<td>98.3% (118/120)</td>
<td>99% (103/104)</td>
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<tr>
<td>aPTT was completed within 6 hrs. of heparin dose adjustment</td>
<td>98.07% (51/52)</td>
<td>98.3% (58/59)</td>
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<tr>
<td>INR level was checked for the patients on oral anticoagulant- Coumadin (Warfarin) for supra-therapeutic and sub-therapeutic level and dose was adjusted accordingly</td>
<td>100% (195/195)</td>
<td>98.62% (215/218)</td>
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<td></td>
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<tr>
<td>Patient education was provided regarding anticoagulation therapy</td>
<td>95% (251/265)</td>
<td>94.09% (303/322)</td>
<td></td>
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<tr>
<td><strong>NPSG. 03.06.01 EP1</strong></td>
<td>Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented; a list may be used for documentation, but a separate list is not required.</td>
<td>98% (650/664)</td>
<td>98% (598/612)</td>
<td></td>
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</tbody>
</table>

For patients, receiving IV heparin baseline CBC and aPTT were ordered within 24 hrs prior to first heparin order.

For patients receiving IV heparin, aPTT was ordered for 6 hours after initiation.

For patients, receiving Coumadin (warfarin), INR is done and checked to see the therapeutic level (2 to 3). If it is below than 1.5 or sub-therapeutic and above than 4 or supra-therapeutic dose adjustment is required to achieve the therapeutic level.

Documentation for Patient Education is entered and verified either in the Hard Copy or in HealthBridge Medical Record.

1. The hospital defines the types of medication information (for example, dose, route, frequency) to be collected in different settings and patient circumstances. Examples of such settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, diagnostic settings, behavioral health, and other locations where medications may be prescribed.
2. Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.
| NPSG. 03.06.01 EP2 | Define the types of medication information to be collected in non-24 hour settings and different patient circumstances. | See the Policy | See the Policy | See the Policy | Attached Policy
1. Examples of non-24 hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings. 2. Examples of medication information that may be collected include name, dose, route, frequency, and purpose. |
| NPSG. 03.06.01 EP3 | Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify discrepancies. | 98% (650/664) | 98% (598/612) | During admission the list of information from the patient and compare it with the new order and any changes thereafter. The patient’s medication information is updated during the patient’s stay in the hospital to reflect new and revised medication orders and to resolve any discrepancies. Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. |
| NPSG. 03.06.01 EP4 | Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter. | 99% (662/664) | 99% (606/612) | Copy to the Patient and or to the Family member. Providing the patient written medication information is necessary only when medications are deleted or added or doses or frequencies are changed during the encounter or stay within the hospital. When the only additional medications prescribed are for a short duration, the medication information the |
| NPSG. 03.06.01 EP5 | Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter. | 99% (662/664) | 100% (610/612) | Patient Education. Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are deleted, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. |  
| NPSG. 07.01.01 | CDC hand hygiene guidelines | See Infection Control Report | See Infection Control Report | See Infection Control Report | See Infection Control Report | Dept. of Infection Control  
| NPSG. 07.03.01 | HC-associated infection & Multidrug-resistant organism (MDRO) & its reporting. | See Infection Control Report | See Infection Control Report | See Infection Control Report | See Infection Control Report | Dept. of Infection Control  
| NPSG. 07.05.01 | Surgical site infections (SSI) preventing programs. | See Infection Control Report | See Infection Control Report | See Infection Control Report | See Infection Control Report | Dept. of Infection Control  
| NPSG.07.06.01 | Implement evidence-based practices to prevent catheter-associated Urinary tract infections (CAUTIs). | See Infection Control Report | See Infection Control Report | See Infection Control Report | See Infection Control Report | This new requirement requires accredited hospitals and critical access hospitals to implement evidence-based practices to prevent catheter-associated urinary tract infections (CAUTIs).
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>15 Patients were identified after assessment</th>
<th>6 Patients were identified after assessment</th>
<th>Identification is done through nursing database for suicidal risk assessment for every patient. 100% compliance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG. 15.01.01 PC.01.02.13</td>
<td>Suicide risk assessment</td>
<td>5 Patients were identified after assessment</td>
<td>6 Patients were identified after assessment</td>
<td>5 Patients were identified after assessment</td>
</tr>
<tr>
<td>PC. 02.01.19 HR.01.05.03</td>
<td>Improve recognition and response to changes in a patient's condition</td>
<td>60 Adult Cardiac arrest &amp; 80 Adult non-cardiac arrest</td>
<td>74 Adult Cardiac arrest &amp; 50 Adult non-cardiac arrest</td>
<td>This standard represents the number of Adult Non-cardiac arrests. It comes from CPR committee report.</td>
</tr>
<tr>
<td>UP -01.01.01</td>
<td>Pre-op verification process (U.P.)</td>
<td>100% (105/105)</td>
<td>100% (105/105)</td>
<td>OR procedures</td>
</tr>
<tr>
<td>UP-01.02.01</td>
<td>Surgical site marking (U.P.)</td>
<td>100% (105/105)</td>
<td>100% (105/105)</td>
<td>OR procedures</td>
</tr>
<tr>
<td>UP-01.03.01</td>
<td>“Time-out” before surgery(U.P) for BED SIDE procedures and OR and completed universal protocol form</td>
<td>100% (157/157)</td>
<td>100% (111/111)</td>
<td>BP= Bedside Procedures (PICC line, Lumber Puncture, Circumcisions, Nerve Block, A- Line (arterial), Femoral Access, Gastrostomy tube replacement, Arteriogram etc. The UP1 form is incomplete, actual “Time-Out” pre-op, site, and side verification is accurate.</td>
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</tbody>
</table>