



Patient, Procedure and Site Verification

Over the past year, we have instituted practice to ensure verification of correct patient, procedure and site in our operating rooms. The JCAHO now has a standard that mandates this level of verification for all surgical and/or invasive procedures that require informed consent carried out in any location in the Hospital, including outpatient locations (e.g., clinics, special procedure areas, Emergency Departments, Interventional Radiology, Greenspring Station, etc.). For procedures carried out in these areas, the health care provider performing the procedure will initiate a “time-out” to ensure correct patient/site/procedure, availability of special equipment, and any special requirements. Other participants may include nurses and other personnel who will participate in the procedure.

For all invasive procedures involving right/left distinction, multiple structures (such as fingers and toes) or levels (as in spinal procedures), site marking is required. Exemptions to the site marking requirement include procedures performed through an orifice (e.g., endoscopy, cystoscopy); line placement; lumbar puncture; cases in which the catheter insertion site is not predetermined (e.g. cardiac catheterization); incision and drainage; bone marrow aspirate and/or biopsy. Site marking is not required if there is an obvious wound or lesion that is the site of the intended procedure. Also, for cases that would otherwise require site marking, if the practitioner remains with the patient continuously from the time of consent to the time of procedure, then site marking is not required. In emergency cases site marking is not required, although a “time out” might still be appropriate.

In cases in which site marking is not required, it is still mandated to have a “time out” prior to the procedure to verify correct patient and procedure. Even when there is only one person performing the procedure, a brief pause to confirm the correct patient, procedure and site is appropriate. Details of the “Patient, Procedure and Site Verification Policy” can be found at www.insidehopkinsmedicine.org/icpm and details of the JCAHO requirements can be found at www.jcaho.org (click on “Universal Protocol”).

Autoparsing of Clinic Notes

We are pleased to announce that we are going to expand the highly successful automatic parsing of the Discharge Summaries into the EPR Problem, Allergy, and Medication List to now include clinic notes. Over the past year, nearly 350,000 problems, allergies, and medications have been added to patient PAM lists in EPR. This has been done by automatically parsing your Discharge Summary dictation and offering you candidates for the PAM list when you sign your notes. We want to build on that success by turning on the same feature in clinic notes.

When you dictate your clinic notes, dictate the words "problem list" or "allergy list" or "medication list" when you wish to include them in your note. These terms and the list of problems, allergies, and medications will then appear in your note and be presented to you as candidates for the PAM list when you sign your note. This will work in the note in any location in which you choose to dictate this information. Last, please be aware that the format in the note will appear, for example, as: Problem List: Chest Pain; GERD; Peripheral vascular disease; etc.

Thank you for using the new automatic parsing feature in your clinic note dictations. It is an important part of our clinical documentation and our JCAHO accreditation strategy.

Patient Safety Net

Patient Safety Net is the new online reporting system. You are encouraged to report any event, whether it is an event that reaches a patient or a near miss. Service and safety concerns are also reportable. Examples of reportable events include errors or complications of procedures/treatment/tests (procedure delays, supply issues, delayed specimen, unplanned transfer to ICU, Pneumothorax, etc...). Events can be entered by going to the public workstation home page and selecting "*PSN-Report an Event or Service Concern*" (http://www.insidehopkinsmedicine.org/jpl/uhc/psn_gateway.html). Formal training will be provided to physicians in the near future, but in the meantime, please ask for assistance from the nurse manager or charge RN when reporting events.

Patient Safety Grand Rounds

Please join us for Patient Safety Grand Rounds this Thursday October 28th, 11 a.m. -12 noon, in Hurd Hall. Professor Didier Pittet, MD, MS, Infection Control Program, The University of Geneva Hospitals, will be presenting "Hand Hygiene Promotion: Individual or Institutional Challenge?" Dr. Didier Pittet is the primary author of the CDC guidelines and chair of the new WHO Patient Safety Indicator Report.

Safety Attitudes Questionnaire

Please participate in the organization-wide safety attitudes survey. The survey will record caregiver attitudes related to the climate or culture of safety throughout the organization and will be administered every Fall. Understanding caregiver attitudes regarding safety is critical if we are to improve safety here at Hopkins. The Residency Coordinators and the Clinical Administrators will be distributing and collecting the surveys from the physician staff. Return date for the surveys is October 29th. Please forward any questions to Dana Moore at dmoore@jhmi.edu.

National Patient Safety Goals (NPSGs)

One of the JCAHO NPSGs is to improve the effectiveness of communication among caregivers. For verbal or telephone orders, or for telephonic reporting of critical test results, the complete order or test result should be verified by the person receiving the order or test result by having the person receiving the order or test result "read back the complete order or test result." "Critical test results" is not limited to laboratory tests; it applies to all laboratory tests including imaging studies and to all caregivers, including physicians. Whenever possible, the receiver of the order should write down the order, read it back, and receive confirmation from the individual who gave the order. The important point to remember is that this is a read-back process; simply repeating an order is not sufficient.

Risk Management Seminars

Risk Management Seminars will be held on the following dates in 2004. Contact your departmental credentials coordinator if you are unsure whether you need to attend.

November 11	5:30 - 6:30 pm	Hurd Hall
December 13	5:30 - 6:30 pm	Hurd Hall

JHH Medical Staff News
Beryl J. Rosenstein, M.D., *Vice President, Medical Affairs*
Pamela Shafer, *Director, Medical Staff Administration*
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Safety Tips: Proper Identification of Patients is the responsibility of every team member.

TWO CASES IN POINT...

- Two patients presented to the ED at about the same time. One male, one female; one GI bleeding, one vaginally bleeding. Both were typed and crossed. The female patient received blood products that were typed and crossed and labeled for the male patient.
- A patient was taken to the OR from the SICU. During the course of the surgical procedure, the patient required transfusion. After the transfusion started the staff noted that the plate that accompanied the patient did not belong to the patient. The patient received a small amount of the transfusion.

SYSTEM FAILURES:

The staff that completed the requisition forms was different staff than the staff providing direct care to the patients in question.

- We have changed our policies and practice to mandate a “time out” prior to the beginning of an operative or invasive procedure. This allows the team caring for the patient an opportunity to verify the patient’s identity using, among other things, the patient ID band.

When checking the blood product immediately prior to transfusion, staff either stepped away from the bedside or did not look under the surgical drapes, so they were unable to use the patient ID band to verify the patient’s identification.

- Staff transfusing blood products should consider having a procedural time out to assure that they take the time to verify the identity of the patient with all the tools available to them, including the patient ID band.