Patients expect that the credentials held by their practitioners represent the experience, knowledge, and skills needed to provide quality patient care. A practitioner who doesn’t possess the credentials required to provide appropriate patient care could cause harm to the patient. And this could ultimately lead to serious risk management issues, negative publicity for the health care organization, or potential liability actions. Protecting patients must be a top priority of health care organizations, so credentialing must be a top priority too.

Unfortunately, the size and complexity of the health care educational and training systems make it easy for credentials fraud to occur. Fraudsters can easily create documentation through modern technology to support their claimed credentials. So addressing problems in primary source verification of practitioner credentials is crucial.
CASE STUDIES

Educating the Board of Safety

Learning how other organizations address risks can spark ideas about how to address similar risks in your own organization. The approaches explained in this case study are presented only to provide insight into possible actions to adapt for your organization’s scope and services.

NOTE: The case study profiles the actions of a real, specific organization, although its name and location are de-identified.

CHALLENGE

Improve various safety measures.

ORGANIZATION

A non-for-profit health system with 13 hospitals and numerous specialty programs. It has affiliated physicians and 24,000 employees.
Hundreds of curated content:

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STAFFING
STRATEGIES
TOOLS
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FAQs

Patient Identifiers

Q: Why is it so important to have “two identifiers”?

A. Two identifiers are vital to do the following:

1. Reliably identify the individual as the patient who is supposed to get the service or treatment AND
2. Match the service or treatment to the patient.

SO

The two patient-specific identifiers must connect directly to the patient.

ALSO

The same two identifiers must connect directly to the patient’s medications, blood products, or specimen containers (such as on an attached label).

Q: What do you mean by “two patient identifiers”?

A. Both identifiers may be in the same place, such as an armband. It’s the patient-specific information that’s the “identifier.” The actual armband (or other item) doesn’t count as an identifier.
INFOGRAPHICS

Types of Patient Safety Events

To properly address patient safety events, you need to know what they are and how they differ from each other. The chart below helps you to understand the relationship and differences among types of patient safety events.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Relationship to Related Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety event</td>
<td>An event, incident, or condition that could have resulted or did result in harm to a patient.</td>
<td>This term covers all the others below. Note: A patient safety event isn’t the same as an error—a mistake that causes harm; or a failure to carry out a planned action as intended, or an application of an incorrect plan. An error may not be patient related, like all patient safety events are.</td>
</tr>
<tr>
<td>Adverse event</td>
<td>A patient safety event that results in harm to a patient.</td>
<td>A specific type of adverse event is an adverse drug event—an injury resulting from a medical intervention related to a medication, including harm from an adverse drug reaction or a medication error.</td>
</tr>
<tr>
<td>Near miss</td>
<td>A patient safety event that did not reach the patient.</td>
<td>This is also known as a close call. These are typically process variations that pose a significant chance of a serious adverse outcome if they occur again.</td>
</tr>
<tr>
<td>No-harm event</td>
<td>A patient safety event that reaches the patient but does not cause harm</td>
<td>Note that the difference between this patient safety event and a near miss is that this reaches the patient.</td>
</tr>
</tbody>
</table>
Disaster Preparedness Program Example

All example policies, procedures, and plans are offered as examples only. You should never copy an example policy, procedure, or plan to use as your own. They must match your practices, so use examples for reference only.

Mission Statement
Consistent with the mission, vision, and values of Haven Hospital to provide safe care, this program establishes the parameters of its response to emergencies and natural or other disasters that have the potential of occurring within the community.

Purpose
To define the Disaster Preparedness Program to guide the organization's response to situations that pose an immediate danger to the health and safety of patients, staff, and visitors within the hospital; to respond to disasters in the community; to return the hospital to a normal status; and to comply with regulations.
Job Summary

Provides oversight and direction of the facility in order to ensure safe conditions, prevent accidents and injuries, and reduce and control hazards and risks. This involves coordinating and managing risk assessment and risk reduction activities in the physical environment. It also involves integrating and coordinating the activities and functions of the overall facility management and safety structure. This individual also develops performance improvement measures with quality management for use in evaluating important systems and to identify needed improvements to reduce and control risks in the care environment.
STRATEGIES

Post-Administration Medication Monitoring

These strategies are suggestions of activities and approaches your organization can choose to use. Some are evidence-based; others are simply ideas to try. Be sure to consider the unique needs of your organization when selecting strategies.

Use a team-based approach.

- **Shared responsibility**: Engage nurses, support staff, and pharmacists in monitoring activities. NOTE: This needs to be very well planned, from the perspective of establishing expectations, holding staff accountable, and documenting findings.

- **Standardize the process**: Work with staff to develop a process for reporting all adverse effects of medications as part of your hospital’s overall quality program.

Utilize integrated technology for documentation.

- **Electronic documentation**: Switch to using electronic medical records for better documentation. Be sure that physicians, pharmacists, and laboratory staff all have access to the same records to allow real-time decision support and safety checks.

- **Tracking tests**: Laboratory results may show the results of medications. Make sure your system has the ability to track laboratory tests and send alerts if follow-up tests are overdue.
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Tools
Postsurgical and Postprocedural Safety Assessment Checklist

This checklist contains questions about postsurgical and postprocedural care. You can use it to assess the safety and quality of your organization's postoperative care. Ideally, all answers should be Y for Yes (unless they aren't applicable). If the answer is N for No, record the changes that are needed to address the issue.

<table>
<thead>
<tr>
<th>During Recovery</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>If No, Note Changes Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient's physiological status assessed immediately after the surgery/procedure?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the physiological assessment include all relevant metrics, such as vital signs, pain control, rate and type of intravenous fluid, urine and gastrointestinal fluid output, other medications, and laboratory investigations?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient's physiological, mental, and pain status monitored after the surgery/procedure?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When the patient's status is monitored, does this include medical and nursing observations, specific comments on the surgical/procedural site, any complications that develop, and any changes made in the treatment or care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Organization: ____________________________ Date: ____________________________
Department/Unit: ____________________________ Name of Reviewer: ____________________________

Notes:
- Name and date of organization and reviewer.
- During Recovery section includes questions about the patient's status assessment.
- Questions cover various aspects such as physiological status, monitoring, and medical observations.
- Instructions for recording changes if answers are No.
The following represent some questions that could be asked during a tracer. Use them as a starting point to plan your own tracers. Use the topics to help organize the questions you want to ask. You may want to copy and paste the questions into a Tracer Form.

<table>
<thead>
<tr>
<th>Tracer Question</th>
<th>Topic</th>
<th>Answer Correct</th>
<th>Follow-Up Needed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Can you describe how the event unfolded?</td>
<td>Emergency Preparedness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How did the organization lock down the ED?</td>
<td>Emergency Preparedness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How did the organization address potential ventilation issues?</td>
<td>Utilities Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How did the organization work with its community partners during the event?</td>
<td>Emergency Preparedness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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VIDEOS
JCI Consultants Say
Quality Improvement Process: Leadership Role

QUALITY IMPROVEMENT PROCESS:
Leadership Role