Areas For Improvement

• Medication Orders are Clear and Accurate
  Preprinted Order Sheets and Forms
  Resume Orders
• Timed Medical Record Entries
  Dating & Timing
  Legibility
• Physician/Provider Orders
  Physician Orders Not Clarified/Followed
• Look-alike/Sound-alike Medications
• History & Physicals
• Unacceptable Abbreviations
• Universal Protocol: Time Out
• Restraints
• Suicide Risk

Medication Orders are Clear and Accurate (MM.04.01.01)

• All preoperative orders are automatically cancelled and must be completely rewritten after the surgery with the exception of all local anesthesia and Monitored Anesthesia Care (MAC) procedures. In this circumstance, “resume orders” (for example, resume all medications, resume previous orders, resume diet orders, etc.) is not an acceptable order.

• All orders must be written in entirety, including drug, dose, route, frequency.

• If “prn” must include indication for use and other special instructions.

• All preprinted forms are reviewed at a minimum of every 3 years for content relevance to current practice.

• Forms not reviewed within this timeframe are communicated to patient care areas as expired and should not be utilized.

• The Director and the Physician Leader are accountable for updating policies and preprinted forms whenever evidence-based practices change and are implemented. They are accountable for submitting revisions to the Clinical Standards Committee and the Forms Committee for review and approval.

• Any staff member who is aware of the need to update a preprinted form due to a change in practice, should notify the Director of Medical Records.

Timed Medical Record Entries (RC.01.01.01)

• In order for all members of the healthcare team to understand when care is provided and by whom, all medical record entries must be dated, timed and signed legibly.

• Verbal order co-signatures must also be dated and timed when signed.

Patient Safety & Quality Improvement

St. Peter’s compliance with national standards for patient care and patient safety was recently evaluated in a survey by The Joint Commission. While the results of the survey were generally positive, some findings will require the immediate attention of St. Peter’s physicians.

The purpose of this newsletter is to share with St. Peter’s health care providers, the recommended areas for improvement to meet evidence-based standards. These standards and practices support St. Peter’s commitment to patient care, patient safety and positive clinical outcomes.

In addition to this newsletter, over the next few months St. Peter’s will be conducting a series of intensive two-week campaigns to further highlight these recommended improvements and re-educate staff of their importance.

Dedicated to our healing ministry and committed to improving the health and well-being of the community, St. Peter’s Health Care Services strives to be a premier regional health system. As a collaborative, integrated continuum of care that is person-centered and spirit-driven, we will assure that services are accessible, high-quality, low cost and demonstrate high levels of satisfaction.
**Physician/Provider Orders (PC.02.01.01)**

- All physician/provider orders must be written legibly, in unmistakable terms, using only St. Peter’s Hospital approved abbreviations and signed by the individual writing the order.
- Orders that are incomplete, illegible or otherwise unclear must be clarified with the physician/provider prior to implementation.
- Physician/provider orders are carried out until cancelled by a written/verbal order with the exceptions as outlined in the linked policy Physician/Provider Orders.

**Look-alike/Sound-alike Medications (NPSG.03.03.01)**

- Physicians/Providers are encouraged to neatly print the Look-alike/Sound-alike medication names on all handwritten orders and have the names spelled back with the read-back on all verbal orders.

**History & Physicals (RC.01.03.01)**

- Any History & Physical (H&P) performed prior to patient arrival for inpatient or outpatient services must be updated if performed within 30 days.
- For patients that are known to be having an outpatient or inpatient procedure, the H&P will be updated prior to the procedure.
- For medical inpatients, the H&P done prior to patient arrival will be updated within the first 24 hours of the inpatient admission.
- An H&P update must describe any changes to patient’s history, physical exam, medications/doses, or allergies that have occurred since the H&P was completed.
- Form MDMISC-006 History & Physical Reassessment is available on DocuShare to record the H&P update. This form will be placed in the charts of all direct admissions by the Information Associate.
- An H&P performed more than 30 days prior to patient arrival will not be accepted, a complete H&P must need to be performed in this situation.

**Unacceptable Abbreviations (NPSG.02.02.01)**

- Unacceptable abbreviations must not be used in any medication related documentation.
- Review list of Unacceptable Abbreviations.
- Reports from MD offices that are intended to become part of the patient’s medical record must not contain unacceptable abbreviations.

**Universal Protocol (UP.01.03.01)**

- Time-out must be initiated by the practitioner performing the procedure.
- Time-outs must be performed and documented in each department where surgical or invasive procedures are performed.
- New Special Procedures Patient Safety Briefing form must be used to document all steps of the universal protocol, including time out, in ALL areas where invasive procedures are performed.
- The OR/Cardiac Surgery OR will continue to use the Surgical Patient Safety Briefing.

**Restraints (PC.03.05.05)**

- Restraint orders may be for any number of hours within one calendar day.
- Continued use of restraint requires the physician/provider to examine the patient “face to face” before writing the renewal order. A physician/provider must write the renewal order on the Patient Restraint Physician/Provider Order Sheet.
- No telephone orders for restraint renewals will be accepted.

**Suicide Risk (NPSG.15.01.01)**

- Effective 12/31/09, any patient who is identified at risk for suicide must be assessed using the Suicide Assessment worksheet as outlined in the revised policy: Psychiatric Emergencies. Identifying a patient at risk can occur through multiple ways such as nursing assessments, observation and response, presenting problem, history and physical, psychosocial assessments, conversations and statements and/or family feedback.
- The Suicide Assessment Worksheet includes a scaled risk assessment that yields a determination of level of risk-low-medium-high and specific interventions based on each level of risk.
- The person identifying the patient at risk may seek assistance in completing the Suicide Assessment worksheet from the nursing supervisor, case manager or social worker (or on-call) and/or psychiatry on-call for support and assistance.

We appreciate your feedback as we continue to incorporate these evidence-based practices into the culture of patient safety at St. Peter’s Hospital. Please contact Eileen Tuffey-Coleman, Director, Patient Safety & Quality Improvement, St. Peter’s Hospital, at 525-1230 or etuffey@sphcs.org.