King Abdulaziz University Hospital Jeddah . . . .

Quality Newsletter

Annual Ceremony of Excellence and Loyally Excellence for "Quality Management" and its members

١٤٣٨ هـ

hospital-tqm@kau.edu.sa

Issue 2
June
2017

TABLE OF CONTENT :

Celebrating Another Achievement

By: Mr. Hussam Al-Baz , Director of Quality Management Department

The ***Awarding Ceremony for Excellence and Loyalty*** was held last 23/7/1438H in the Hospital's Main Auditorium. This annual event is under the sponsorship of *H.E.* President Abdulrahman Al-Youbi, King Abdulaziz University. And among the chosen recipient was the **Quality Management** receiving a **Trophy of Excellence**.

شكر وتقدير

قسم الجودة

إن الرقي والتقدم الذي تشهده كلية الطب والمستشفى الجامعي ماهو إلا بذل جهد وعطاء متميز وهمم عالية من الإدارات أمثالكم ، التي أثرت تأثيرا إيجابيا في المحيط الذي حولها ، وسطرت خطوط نجاحها بكل إتقان .

وعرفانا منا بتلك الجهود نتقدم لكافة منسوبي قسمكم الموقر بخالص الشكر والتقدير لأدائكم المتميز متمنين لكم دوام التوفيق .

عميد كلية الطب

أ.د. محمود بن شاهين الأحول

To the Director and entire staff of Quality Management, warmest congratulations for a well-deserved recognition!

Sentinel Event Alert: Radiation risks of diagnostic imaging

By:Ahlam Alghanmi , Quality Improvement Advisor

In September 2011 The Joint Commission (TJC) issued a Sentinel Event Alert on the radiation risks associated with diagnostic imaging. The alert underscored the value and effectiveness of diagnostic radiation but also highlighted the risks associated with **repeated dosing** and the **cumulative effect of multiple radiation doses over time**. The alert reviewed:

- The challenge of providers ordering diagnostic tests involving radiation without any knowledge of when a patient's last exposure to radiation was or how much total radiation a patient has received.
- The value of diagnostic radiation.
- The lack of agreement on how much radiation is too much or if there may be timeframes between radiation exposures that make it safer.
- The risks associated with using insufficient radiation which can increase misdiagnosis/delay treatments.
- The inherent risks associated with ionizing radiology

Contributing factors to eliminate avoidable radiation dosing

There are actions that organizations can take to eliminate avoidable radiation. First, staff should be aware of the contributing factors to, and activities that can help eliminate, avoidable radiation doses, which include:

- A comprehensive patient safety program, including education about dosing in imaging departments.
- Awareness of the potential dangers from diagnostic radiation among organizational leadership, hospital staff and patients.
- Adequate awareness among physicians and other clinicians about the levels of radiation typically used and related risks.
- Training on how to use complex new technology.
- Guidance in the appropriate use of potentially dangerous procedures and equipment.
- Adequately trained and competent staff.
- Knowledge regarding typical doses.
- Clear protocols that identify the maximum dose for each type of study.
- Consulting with a qualified medical physicist when designing or altering scan protocols.
- Communication among clinicians, medical physicists, technologists and staff.
- Safety, operational and functional checks of the equipment before initial use and periodically thereafter.

Actions suggested by The Joint Commission

Health care organizations can reduce risks due to avoidable diagnostic radiation by raising awareness among staff and patients of the increased risks associated with cumulative doses and by providing the right test and the right dose through effective processes, safe technology and a culture of safety.

In addition, The Joint Commission:

- Endorses the creation of a national registry to track radiation doses as the start of a process to identify optimal and reference doses.
- Encourages manufacturers to incorporate dosage safeguards into equipment and to capture dose information in the patient's electronic medical record and national dose registry.
- Supports stricter regulations designed to eliminate avoidable imaging and monitor the appropriateness of self-referred imaging studies (referral of a patient to a facility in which the referring physician has a financial interest).

Resources

- The Joint Commission Standards FAQs on radiation overdose (accessed May 12, 2017).

Are You Guilty? 5 Common Errors New Nurses Make

Can you still remember the first nursing error you made on your shift?

(By Cres Javonillo & Biji Thomas)

While not all mistakes **can cause harm to our patients**, most of them are excellent sources of embarrassment.

If you're a new nurse, **you may probably find humor** and learning in these **five common errors we all tend to commit as newbies.**

1. Calling a patient by the wrong name.

This is one of the most common, yet fatal, errors most new nurses commit. While there's almost nothing harmful in addressing the patient with the wrong name while talking to him, it's a whole different story when it comes to giving medications. You can end up giving him the wrong meds at the wrong time, route and frequency.

Lesson: To avoid medication errors, it is essential that you know the **Rights of Drug Administration**. Ask the patient his full name and double check it against his ID band and his chart with another staff. Even if you're aware of who the patient is, make it a point always to ask and verify.

2. Updating the doctor without the complete information at hand.

Calling the patient's attending physician, had to rehearse what to say before calling but couldn't answer his first question because you forgot the result of what you supposed to update him.

Lesson: If you're going to call the doctor, have your patient's chart with you and all the necessary lab and imaging results at hand. This is particularly important if you're going to call the physician at 2 o'clock in the morning. Before you make that call, be prepared with your assessment findings.

3. Committing a medication error.

Almost all nurses have committed a medication error once in their professional service. While some nurses were able to catch their mistakes before they caused harm to their patients, there are a few number of cases that resulted in lethal threats.

Lesson: There are a lot of ways to **avoid medication errors**. If you commit one, however, it's essential that you avoid covering it up. Own up and take responsibility to tell the healthcare team, your senior nurse, and the physician to ensure your patient's safety. At some point, you may also need to tell your patient about it.

4. Not knowing enough about the patient's condition.

Most of the time, patients and relatives feel intimidated and shy that they tend to ask nurses questions they would want their doctors to answer. If you encounter this, be prepared to give an honest response. If you're not sure about it, politely tell them to address the question to the doctor instead or you'll gather more info and you'll get back to them soon.

Lesson: Always stay updated with your **patient's care plan**. During the day, his doctors can create changes in his diet and medications which you need to be aware of. The last thing you want to happen is for your patient to tell you what the doctor told him he can and can't eat.

5. Not asking questions.

As a new nurse, it's common to feel intimidated and shy, particularly if you're working closely with veterans. Unfortunately, this behavior often leads to why nurses unknowingly commit errors.

Lesson: Always ask. If you're not sure about something, ask. Don't be a **know-it-all nurse**! If an order seems wrong, clarify. If it's the first time you're administering something, look for assistance. Veteran nurses today didn't get their expertise and skills from nothing. They got it from other experienced nurses that were there when they were still new like you.

What were your first errors as a nurse? What did you learn from them?

Reference: https://nurseslabs.com/guilty-five-common-errors-new-nurses-make

HANDOFF COMMUNICATION

Transfer of Client Information at Transition Points

(By: Corazon C. Albino & Manju K. Joseph - Quality Coordinator)

WHAT IS A HANDOFF COMMUNICATION?

A handoff, also known as a *"handover"* or *"patient care transfer,"* is a standardized interactive process of transferring patient-specific information between health care practitioners and patients/families *during a period of care and upon discharge* for the purpose of ensuring the continuity and safety of the patient's care.

Important information transferred during a period of care should include: client's status, medications, treatment plans, advance directives, and significant status changes and information transferred upon discharge should include: client's discharge diagnoses, treatment plans, medications, and test results.

HANDOVERS OF PATIENT CARE WITHIN A HOSPITAL OCCUR:

- Between health care providers
- During shift changes
- Inpatient units to diagnostic or other treatment departments
- Patient is moved from an intensive care unit to a medical unit or from an Emergency Department to the Operating Theater

WHO DOES THE HANDOFF COMMUNICATION?

All who is involved in Patient Care

WHY HAND-OFF COMMUNICATION IS IMPORTANT?

It has been estimated that "*80 percent* "of serious medical errors involve miscommunication during the hand-off between health care providers. The majority of avoidable adverse events are due to the lack of effective communication.

Patient care circumstances that can be critically impacted by poor communication include verbal and telephone patient care orders, verbal and telephone communication of critical test results and handover communications. Breakdowns in communication can occur during any handover of patient care and can result in *adverse events*.

An effective communication either by electronic, verbal, or written which done in a timely, accurate, complete, unambiguous, and understood manner by the recipient, reduces errors and results in improved patient safety.

GOALS OF A HANDOFF COMMUNICATION:

1. Provide handoff in the same manner each time
2. Two-way exchange of information
3. Limit distractions and interruptions
4. Standardized, critical content for interactive communication between

PATIENT, FAMILY***, CAREGIVER***, and ***HEALTH CARE PRACTITIONERS*** including an opportunity to ask and respond to questions

SAFE PRACTICES FOR EFFECTIVE COMMUNICATION:

- Limiting verbal communication of prescription or medication orders to urgent situations in which immediate written or electronic communication is not feasible.
- Development of guidelines for requesting and receiving test results on an emergency or STAT basis, the identification and definitions of critical tests and critical values, to whom and by whom critical test results are reported.
- Writing down, or entering into a computer the complete order or test result by the receiver of the information. They require a process for verification of information received, including "*Repeat-back or Read-back"*, when appropriate.
- Use of standardized methods, forms, or tools to facilitate consistent and complete handovers of patient care (e.g. transfer forms, checklists, SBAR and electronic medical record)

References:

- *QIAP 2016 ROP Handbook*
- *JCIA Accreditation Standards,6th Edition*
- *Handoff Communication- Safe Transition in Patient Care by: Kurt A.Patton,MS,RPH*

Quality of Life

By: **-Yasmeen Ashour**

Quality is the standard of something as measured against other things of a similar kind; the degree of excellence of something.

Quality cloud be found in many areas in our life and it is not only in healthcare for example: Education, Physical environment , Staffing arrangements, Leadership service management and quality of life.

Quality of Life is the general well-being of individuals and societies, outlining negative and positive features of life.

Also, Quality of life is the degree of satisfaction an individual has regarding a particular style of life. Although assessment tools are available to evaluate physical and social dimensions, an individual's general sense of

Well

being or satisfaction with the attributes of lifeis more difficult to evaluate

There are eight domains for Quality of Life:

1. Emotional well-being – contentment, self-concept, lack of stress.
2. Interpersonal relations – interactions, relationships, supports.
3. Material well-being – financial status, employment, housing.
4. Personal development – education, personal competence, performance.
5. Physical well-being – health and health care, activities of daily living, leisure.
6. Self-determination – autonomy / personal control, personal goals, choices.
7. Social inclusion – community integration and participation, roles, supports.
8. Rights – legal, human (respect, dignity, equality).

Standards related from Accreditation Canada (Work life):

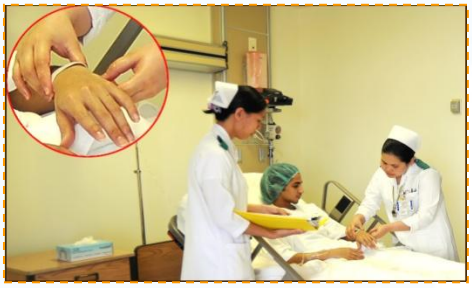
4.0 The organization invests in its people and effectively manages its human resources.

5.0 The organization provides a positive work environment.

References:

- Australian children's education & care quality authority.
- https://en.wikipedia.org/wiki/Quality_of_life
- http://www.communitylivingbc.ca
- medical-dictionary.

The ABCs of Patient Safety



By : NAHQ modified by Sana AlEidarous

A	**Abbreviations are risky , they might be misunderstood**
B	**Blame-free system increases medical error reports**
C	**Credentialing and Privileging to assure the right healthcare provider for the scope of service .**
D	**Documentation; complete and accurate patient record fosters quality and continuity of care.**
E	**Effective communication , safe life .**
F	**Fall prevention protocols**
G	**Getting everyone on the same page and shred.**
H	**Hand Hygiene prevents the spread of Health Associated Infection**
I	**Identification; All patients are positively identified with two patient identifiers prior to initiating any procedure**
J	**Just culture, balances organizational context with appropriate accountability after an error.**
K	**key moments for hand hygiene, before and touching a patient, before aseptic procedures, after body fluid exposure/risk, and after touching patient surroundings.**
L	**Look alike , sound alike medication should be separated**
M	**Medication reconciliation at times of transitions in care**
N	**Needles and other sharps should discard in a sharps disposal container immediately after they have been used.**
O	**Opportunity for improvement**
P	**Periodic preventive maintenance for each equipment**
Q	**Question if it is not clear**
R	**Reconciliation, reconcile medication at admission , transfer and discharge.**
S	**Sentinel events should be reported immediately**
T	**Time-out before any procedure or surgical operation**
U	**Universal Protocols ensures correct patient, correct site and correct procedure**
V	**Value patient perception**
W	**Why , why , why , why , why = root cause analysis**
X	**X- Ray safety protection**
Y	**You can make the difference**
Z	**Zero Error**

Quality Staff Awards

Congratulation to our colleagues for being nominated as the ideal employees

for 2017

Omnia Sharawi | Manju Joseph | Yasmeen Ashour | Crescencia Javonillo

"Quality Management" Contributions

Quality Management participate celebrating with the Lab Department in "Lab Day 2017". The result of patient satisfaction on laboratory services were displayed in charts . Socrative.com web page were utilized to distribute a questions about patient safety ,more than 150 participates answered the questions.

Another Quality Management booth were in " How to be a role model " activity by Saudi Psychologists association in their educational activity in Al-Andalus Mall .

KAUH Quality Management News

Thanks for your time reading the newsletter

Wait for the next issue

Quality Department