GEORGIA DEPARTMENT OF PUBLIC HEALTH
POLICY # DS-08001
SAFE PATIENT CARE IN PUBLIC
HEALTH SETTINGS POLICY

Approval:	███████████████	August 20, 2014
	Carole Jakeway, Director of District & County Operations	Date
	███████████████	9/14/14
	James C. Howgate, Chief of Staff	Date

1.0 PURPOSE

The purpose of these guidelines is to provide general principles relative to the processes, activities and structures necessary for the delivery of safe patient care and the prevention of medical errors in public health settings. These guidelines apply to all public health settings and are intended to foster consistency in safe patient care practices within public health settings.

1.1 AUTHORITY – The Georgia Department of Public Health (DPH) Safe Patient Care in Public Health Settings Policy is published under the authority of DPH and in compliance with the need to prevent medical incidents and assure safe patient care in public health settings.

2.0 SCOPE

This policy applies to healthcare professionals who provide clinical services in public health settings.

3.0 POLICY

The policy of the Department of Public Health is in assurance with the safe provision of public health services, a goal consistent with the mission of public health as well as the entire healthcare system. It is essential for public health professionals to use an evidence-based approach to prevent medical errors and assure safety in providing public health services.

4.0 DEFINITIONS

4.1 Leadership - Safety must be an explicit organizational goal that is demonstrated by clear organizational leadership and professional support as seen by the involvement of governing boards, management, and clinical leadership; a meaningful safety program should include senior-level leadership.

4.2 Best Practices - Feasible prototype systems or preferred approach; shown to reduce errors in the medication process and known methods for improving safety; incorporating evidence based medicine.

4.3 **System** - Set of interdependent elements interacting to achieve a common aim. These elements may be both human and nonhuman (e.g. equipment, technologies, etc.).

4.4 **Medical technology** - Techniques, drugs, equipment, and procedures used by health care professionals in delivering medical care to individuals and the systems within which such care is delivered.

4.5 **Error** - Failure of a planned action to be completed as intended or use of the wrong plan to achieve an aim; the accumulation of errors results in accidents.

4.6 **Medical Incident** - Any unusual or unexpected event or outcome, including but not limited to medical treatment rendered to a patient that may have been inconsistent with established policies, standards, procedures, guidelines, or nurse protocols, regardless of outcome.

5.0 RESPONSIBILITIES

5.1 DEPARTMENT OF PUBLIC HEALTH (DPH) is responsible for the development, dissemination and revisions to the policy.

5.2 DPH DIVISION OF DISTRICT AND COUNTY OPERATIONS (DCO) is responsible for reviewing and coordinating revisions to this policy.

5.3 DPH DIVISIONS, SECTIONS, and PROGRAMS are responsible for referencing this policy in providing programmatic technical assistance to local public health, as appropriate.

5.4 **SUMMARY OF LITERATURE REVIEW**

5.4.1 The research literature related to safe patient care practices is burgeoning. An historical overview of patient safety efforts demonstrates an awareness of the need to avoid harm to patients dating back to the early 19th century. Despite this ongoing sense of awareness, medical errors have resulted in a substantial burden of patient injury, suffering, and death. In an effort to end the cycle of inaction, the Institute of Medicine (IOM) published *To Err is Human* as a call to action with a specific focus on preventing future errors (IOM, 1999).

5.4.2 A selective review of the literature was conducted to examine the body of patient safety research published since the landmark IOM report. Seven peer-reviewed reports published between 2000 and 2010 were selected for review. For the purpose of a more efficient synthesis of current research, only one report was based on original research, while the remaining reports were classified as narrative or literature reviews.

5.4.3 Findings from the literature review reflect an overall focus on system failures rather than individual failures as contributors to medical errors (Carlton & Blegan, 2006; Wolf, 2007). The IOM suggests that poorly coordinated systems of care contribute to unsafe conditions for patients and further recommends that a shift from blaming individuals is necessary to achieve patient safety goals (IOM, 1999). Unfortunately, managers and other supervisory personnel are often non-supportive and perceive individual failures rather than system failures as the cause of medical errors (Carlton & Blegan, 2006; Wolf, 2007).

5.4.4 Contrary to this perspective, system failures such as lack of supplies, equipment failures, or missing medications perpetuate work interruptions for nurses. During medication administration, work interruptions caused by patients, nurse colleagues, or system failures contribute to medication errors (Biron, Lavoie-Trembly, & Loiselle, 2009). The majority of medication errors are attributed to physician ordering and nurse administration of medications. Nurses' poor mathematical competency has been consistently identified as a key cause of medication administration errors (Jones, 2009). Increased patient acuity and patients with complex medical profiles have also been linked to increased medication errors (Carlton & Blegan, 2006). Nurses perceived time pressures and heavy workloads may encourage shortcuts in following protocols (Jones, 2009). Furthermore, nurses' fatigue resulting from extended shifts may result in decreased vigilance to follow protocols and prevent errors (Keller, 2009).

5.4.5 The literature is replete with evidence to support the implementation of patient safety efforts. Research suggests that staffing plans with a higher proportion of registered nurses and experienced nurses are associated with lower medication error rates (Carlton & Blegan, 2006). Medication protocols, protected medication administration times, visual reminders, and double-checking medications have been effective strategies for reducing medication errors in a variety of clinical settings (Jones, 2009). Electronic medical records, computerized physician order entry systems, and bar code reconciliation demonstrate the effective use of technology to help reduce medical errors (Wolf, 2007). Integrated information systems and creative uses of technology can decrease the need for face-to-face communication between health care providers and reduce work interruptions (Biron et al, 2009). Patient safety initiatives that incorporate patient participation as well as institutional policies that encourage full disclosure to patients when errors occur may result in increased patient satisfaction, increased trust, and positive emotional responses from patients (Wilson, 2005, Longtin, Sax, Leape, Sheridan, Donaldson, & Pittet, 2010).

5.4.6 Finally, the reports selected for this review consistently identified the need to deconstruct the culture of blame that currently exists in reporting medical errors (IOM, 1999, Wilson, 2005, Carlton & Blegan, 2006, Longtin et al, 2010). Implementing reporting systems that are non-punitive and allow

analyses for system improvement may present a unique opportunity to develop a culture of safety in public health settings.

6.0 PROCEDURES

6.1 GUIDING PRINCIPLES

6.1.1 Get to zero.

The primary safety goal is to reduce the number of medical errors to zero by focusing on activities that prevent such events. It is important to strive toward preventing all incidents, as each one involves an individual and potential harm to that individual.

6.1.2 Learn from human error.

A culture of blame is counter-productive in patient safety initiatives. Rather than blaming individual healthcare providers, the focus must shift to the lessons learned and applying these lessons to systems and technology that can prevent errors and assure safe patient care.

6.1.3 Focus on best practices.

A substantial body of knowledge related to best practices has been produced by multiple organizations devoted to safe patient care practices. It is important to stay abreast of the most current research, to contribute to this growing body of knowledge, and to implement evidence-based safe patient practices in public health.

6.1.4 Recognize excellence.

Each employee contributes to the delivery of safe patient care. It is important to continuously communicate organizational goals for safe patient care with employees, and to recognize ideas, initiatives, and practices that contribute to safe patient care.

6.2 LEADERSHIP

6.2.1 Each District shall organize a District Medical Peer Review Committee for the purpose of gathering and reviewing information relating to the care and treatment of patients, evaluating and improving the quality and efficiency of health care and reducing morbidity and mortality. See Attachment A for sample by-laws for the organization of the Committee.

6.2.2 All Medical Incidents within the District shall be reported to the District Medical Peer Review Committee as soon as practicable, using the

Attachment B: District Medical Peer Review Committee Medical Incident Report. The Committee shall review each medical incident and provide the necessary follow-up as indicated.

6.2.3 The District will require adherence to the use of Standard Abbreviations consistent with the *Statewide Standard List, Abbreviations, Acronyms and Symbols,* Georgia Department of Public Health, found at: http://dph.georgia.gov/sites/dph.georgia.gov/files/StandardListAbbreviations AcronymsandsymbolsOct2010.pdf

6.2.4 Leaders will recognize safe patient care practices by giving awards (e.g., plaques, certificates, bonuses) for excellence, achievement and/or improvement in patient care safety. These recognition awards may be given to individuals, teams and/or entire County Health Departments.

6.2.5 All leaders, managers and supervisors are expected to create and sustain an organizational culture that focuses on system errors and blame-free reporting.

6.2.6 Leaders will provide opportunities for all leaders, managers and supervisors to learn about a no-blame and no-shame philosophy and its application to medical errors.

6.2.7 Leaders will promote team accountability for safe patient care practices and shared ownership of problem resolution.

6.2.8 Leaders are expected to periodically and directly inspect work areas where medications are stored and administered.

6.2.9 Leaders will designate areas where medications and vaccines are administered and stored.

6.2.10 Leaders will standardize clinic operations within each site on a District-wide basis (e.g., equipment, design).

6.3 BEST PRACTICES

6.3.1 Develop and use checklists to promote the use of safety precautions prior to administering vaccines and/or medications and prior to the provision of other direct patient care services. (See Attachment C for an example of a checklist prior to administering vaccines).

6.3.2 Orientation for new employees must include expectations regarding safe patient practices.

6.3.2.1 Initial and ongoing training related to specific immunizations

6.3.2.2 Education and training related to statutes governing medication administration

6.3.2.3 Develop a method to ensure consistent standards of training related to medication administration

6.3.2.4 Include standardized checklist for medication administration in orientation

6.3.3 Performance Management Plans for all employees must include expectations regarding safe patient practices.

6.3.4 Develop a standardized process/checklist for medication administration.

6.3.4.1 Assessment

6.3.4.1.1 Health history

6.3.4.1.2 Medication history

6.3.4.1.3 History of allergies

6.3.4.1.4 Diet history as indicated

6.3.4.1.5 Patient understanding of medication

6.3.4.1.5.1 VIS statement

6.3.4.1.5.2 Drug fact sheet

6.3.4.1.5.3 Cultural competence and language barriers

6.3.4.1.5.4 Patient indicates understanding of 30 minute observation, as recommended after medication administration

6.3.4.1.6 Contraindications

6.3.4.1.7 Physical exam as indicated

6.3.4.2 Interventions

6.3.4.2.1 Explain purpose and actions clearly

    6.3.4.2.2 Describe key side effects

    6.3.4.2.3 Select medication and check expiration

    6.3.4.2.4 Measure the dose

    6.3.4.2.5 Assure accurate calculation

    6.3.4.2.6 Know systems of weight/volume measurement and age-appropriate dosage and preparation

    6.3.4.2.7 Administer the dose

        6.3.4.2.7.1 Five Rights:
                      Drug, dose, patient, route, time

    6.3.4.2.8 Document the dose immediately

    6.3.4.2.9 Observe the patient for drug effects for 30 minutes, as recommended per protocol

6.3.4.3 Each clinic site will develop a systematic protocol to organize inventory to minimize vaccine/medication errors

    6.3.4.3.1 Examples/Options:

        6.3.4.3.1.1 Color coding vaccines and medications

        6.3.4.3.1.2 Clear glass refrigerator door

        6.3.4.3.1.3 Vaccine basket labeled/color-coded

        6.3.4.3.1.4 Vaccine organized by funding source, age group, or other critical indicator

        6.3.4.3.1.5 Maintain notebook with list of all vaccines and package inserts

6.3.4.4 Each clinic site will develop a systematic protocol for medication preparation that creates barriers to errors

    6.3.4.4.1 Examples/Options

        6.3.4.4.1.1 Color coded tackle box tray for preparing multiple medications

6.3.4.4.1.2 Use pharmacology reference dose calculator

6.3.4.4.1.3 Vaccine PowerPoint with photos of vaccine vials/boxes

6.3.4.4.1.4 Patient drug information sheet

6.3.4.5 Each clinic site will establish procedures for minimizing interruptions during medication preparation

6.3.4.5.1 Examples/Options include, but are not limited to the following:

6.3.4.5.1.1 Establish "Red Zone," "Time Out," "Take Five," "Med Five," or "Give Me Five"

6.3.4.5.1.2 Post "Do Not Disturb," "Do Not Interrupt – Nurse Giving Medication," or "No Interruptions, Please" signs

6.3.4.5.1.3 Nurse to wear sash or vest during medication preparation

6.4 SYSTEMS AND TECHNOLOGY

6.4.1 A system is in place that alerts personnel when the temperature of refrigerated pharmaceuticals is out of standard range, consistent with product package inserts.

6.4.2 When medical errors occur, there is a review of the event to determine needed system changes, identifying factors that contributed to the error, and lessons learned. This review process must include the following components:

6.4.2.1 Review of the patient's clinical record; and

6.4.2.2 Review of the applicable patient care standards, guidelines, protocols; and

6.4.2.3 Interview with the person who administered the medication/vaccine; and

6.4.2.4 Review of the relevant training and orientation previously provided; and

6.4.2.5   Observation of the environment; and

6.4.2.6   Reporting and review of the incident to supervisor, District Nursing Director and District Health Director and others, as appropriate.

6.4.3   Clinic areas must be structured to prevent interruptions of staff while administering vaccines, medications and/or other injections. This may include posting signs such as "Do Not Interrupt Nurse --- Giving Medications." See other examples in the section on Best Practices.

6.4.4   A system is in place that ensures expired medications are removed from stock on a regular basis.

6.4.5   When a multi-dose vial is opened, the employee who opened the vial will write the date the bottle will be discarded on the label as a fraction (e.g., open date/discard date). Discard date will be according to manufacturer's instructions.

6.4.6   Implement a system for rotating drugs that will expire within three to six months to sites that are in need of the drugs or return drugs that will expire within three to six months to the DPH Pharmacy Section.

6.4.7   Use standardized labeling of medications to differentiate between private and Vaccines for Children (VFC) medications.

6.4.8   Use redundant system for monitoring (sensophone and temperature logs) of temperature excursions (lower and upper limits must be in place). All staff must be trained on how to use the sensophone or other electronic notification devices.

6.4.9   Conduct mandatory end-of-month inventory. Some larger clinics will conduct daily inventories, and other clinics may not need to perform reconciliations that often. All clinics must conduct end of month reconciliation for all medications.

6.4.10 Review the five rights during new employee orientation and annual updates to ensure the five rights become a part of every medication administration.

6.4.11 Encourage patient to ask provider if he/she has entered the immunization information into the Georgia Registry of Immunization Transactions and Services (GRITS), thereby ensuring accurate immunization records.

6.4.12 Ensure all health districts/counties have access to a current approved drug reference.

6.4.13 When a drug calculation (e.g., dose, time interval) is required for a drug that is not routinely administered, two nurses must independently perform calculations of the drug dosage before the drug is administered.

6.4.14 Ensure temperature monitoring devices are calibrated per manufacturer's instructions.

6.4.15 Use standardized drug codes throughout each health district.

6.4.16 Use interactive educational modalities to ensure patients understand medication administration, safety and side effects.

7.0 REVISION HISTORY

REVISION #	REVISION DATE	REVISION COMMENTS
0	July 1, 2011	Initial Issue
1	July 9, 2012	Annual review and update. Reformat to new template.
2	August 11, 2014	Changed District/County Safety Committee to District Medical Peer Review Committee.

8.0 RELATED FORMS

ATTACHMENT A – BY-LAWS FOR DISTRICT MEDICAL PEER REVIEW COMMITTEE

ATTACHMENT B – DISTRICT MEDICAL PEER REVIEW COMMITTEE MEDICAL INCIDENT REPORT

ATTACHMENT C – MEDICATION ADMINISTRATION CHECKLIST

ATTACHMENT D – REFERENCES

ATTACHMENT A –
RECOMMENDED BY-LAWS FOR A DISTRICT MEDICAL PEER REVIEW COMMITTEE

I. PURPOSE

The District Medical Peer Review Committee is organized pursuant to O.C.G.A Sections 31-7-130 through -133 for the following purposes:
- gathering and reviewing information relating to the care and treatment of patients, including medical incidents;
- reviewing the general competence of District and County employees in providing health care services to specific patients;
- evaluating and improving the quality and efficiency of health care; and
- reducing morbidity and mortality.

II. MEMBERSHIP IN THE COMMITTEE

The Committee shall consist of no less than three members. A majority of the members shall be licensed by and in good standing with the regulatory body governing one of the following professions:

- Dentist;
- Physician;
- Pharmacist;
- Physical therapist; or
- Registered Professional Nurse or Advanced Practice Registered Nurse.

The District Health Director and District Administrator shall be *ex officio* members of the Committee.

Members may be selected from among employees of the State and County health departments, as well as from the communities served by the District.

III. OFFICERS OF THE COMMITTEE

A. Chair	Prepares meeting agenda and serves as moderator of discussions.
B. Vice-Chair	Acts as Chair in the absence of the Chair.
C. Secretary	Records minutes of meetings, prepares and files records pertaining to the investigation and discussion of medical incidents.

Officers shall be chosen at the first regular meeting of each year, and shall serve for a period of one year.

IV. DUTIES AND SCOPE OF WORK

The District Medical Peer Review Committee will meet as needed to review reports of medical incidents, to discuss ideas for evaluating and improving the quality and efficiency of health care, to discuss ideas for reducing morbidity and mortality, and to review the general competence of District and County employees in providing health care services to specific patients.

The Committee will develop and implement corrective action plans as needed to address gaps in patient safety. The Committee will stay abreast of national standards related to patient safety and will develop procedures that are consistent with national standards and enhance patient safety.

Meetings of the Committee shall be strictly limited to the investigation and discussion of medical incidents, ideas for evaluating and improving the quality and efficiency of health care, ideas for reducing morbidity and mortality and the general competence of District and County employees in providing health care services to specific patients. The Committee shall not discuss matters outside that scope, such as administrative or financial matters, utilization review, or routine credentialing of professionals. Should it become necessary to discuss matters outside the scope of the Committee's duties, the meeting should be adjourned.

V. PROCEEDINGS OF THE COMMITTEE

All proceedings of the Committee and discussion of matters before the Committee, whether in person or by telephone, letter, or email, shall be confidential. No member of the Committee shall disclose to a third party any part of those proceedings, including the fact that a particular patient or incident is or is not under consideration, expect as necessary to implement the recommendations of the Committee. A majority of the membership of the Committee shall constitute a quorum for the conduct of business.

VI. RECORDS OF THE COMMITTEE

All records of proceedings before the committee, including medical incident reports, documents furnished to the Committee for its review, agendas, minutes of meetings, and reports of recommendations, shall be kept separate from any other records of the District. Such records shall not be placed in the medical records of any patient.

The District Administrator and Secretary of the committee shall be responsible for ensuring that the records of the Committee are stored in a secure place, and that access to them is strictly limited to members of the Committee engaged in the business of the Committee.

ADOPTED this ____ day of _____, _____.

_____

CHAIR, District Medical Peer Review Committee

For District _____

ATTACHMENT B –
DISTRICT MEDICAL PEER REVIEW COMMITTEE MEDICAL INCIDENT REPORT

NOTE: This form shall be used to report "medical incidents" to the District Medical Peer Review Committee. A "medical incident" is any unusual or unexpected event or outcome, including but not limited to medical treatment rendered to a patient that may have been inconsistent with established policies, standards, procedures, guidelines, or nurse protocols, regardless of outcome.

This form should be filed with the District Administrator. The purpose of this form is to allow the Medical Peer Review Committee to evaluate the quality and efficiency of District and County personnel in rendering patient care. This form should not be placed in the patient's medical records.

Date of Medical Incident: _____
Date Medical Incident Reported to Supervisor: _____
Date Reviewed by Committee: _____

Name of Patient: _____
Location of Medical Incident (Address, Room): _____

Summary of Medical Incident (Who, What, Where, When): _____

_____

_____

Cite the specific patient care standards, guidelines, protocols, policies or procedures which apply to the above situation and were not followed: _____

_____

_____

Interview with the Employee(s) involved in the incident (Summary of employee's description of the event): _____

_____

_____

Relevant training and orientation (Comment on the extent to which the employee was properly oriented and trained to provide the patient care): _____

_____

_____

Environment: Observation of the Committee regarding the environment where the incident occurred to detect factors that may have contributed to the incident: _____

_____

_____

Committee Recommendations for Follow-Up:

_____

_____

_____

_____

_____

_____

Date: _____   Committee Chair Signature: _____

ATTACHMENT C –
MEDICATION ADMINISTRATION CHECKLIST

ASSESSMENT

- ☐ **Health History**
- ☐ **Medication History**
- ☐ **History of Allergies**
- ☐ **Diet History as Indicated**
- ☐ **Patient Understanding of Medication**
  - ☐ **VIS Statement**
  - ☐ **Drug Fact Sheet**
  - ☐ **Cultural Competence/Language Barriers**
  - ☐ **Patient indicates understanding of 30 minute observation recommended after medication administration**
  - ☐ **Contraindications**
  - ☐ **Physical Exam as Indicated**

INTERVENTIONS

- ☐ **Explain Purpose and Actions Clearly**
- ☐ **Describe Key Side Effects**
- ☐ **Select Medication and Check Expiration Date**
- ☐ **Calculate the Dose Accurately**
- ☐ **Know Systems of Weight/Volume Measurement/ Age Appropriate Dosage and Preparation**
- ☐ **Wash Hands**
- ☐ **Measure the Dose**
- ☐ **Administer the Dose**
  - ☐ **Five Rights**
    - ☐ **Drug**
    - ☐ **Dose**
    - ☐ **Client**
    - ☐ **Route**
    - ☐ **Time**
- ☐ **Document the Dose Immediately**
- ☐ **Request the Patient Remain in Clinic for 30 Minutes after Medication Administration for Observation of Drug Effects per Protocol**

ATTACHMENT D –
REFERENCES

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