

2010

NATIONAL PATIENT SAFETY GOALS

Applicable to Central Louisiana State Hospital (CLSH)



2009/12-tjc-Central Louisiana State Hospital (CLSH)_2Ad1Ca2Fr*S&R

1. Improve the accuracy of patient identification.

- CLSH utilizes the following two identifiers: patient name and patient photograph.
- All specimen containers are labeled in the presence of the patient.

2. Improve the effectiveness of communication among caregivers.

- Critical lab and diagnostic results are measured and assessed for timeliness.

2. Improve the Safety of Using Medications

- All medications on and off the sterile field are labeled. (Applies only to Dental Clinic)
- The Anticoagulant Therapy Policy is used on all patients on anticoagulants.

7. Reduce the risk of health care-associated infections.

- CLSH employees comply with CDC guidelines by washing hands for a minimum of 15 seconds.
- CLSH will maintain 90% or greater compliance with hand hygiene guidelines.

8. Accurately and completely reconcile medications across the continuum of care

- A complete list of the patient's medications is obtained upon admission.

- A complete list of the patient's medications is communicated to the next provider of service at the time of transfer or discharge.
- A complete medication review is done upon receiving a patient in transfer from another medical facility after an overnight stay.
- A complete list of medications is also provided to the patient on discharge.

15. The organization identifies safety risks inherent in its patient population.

- CLSH identifies patients at risk for suicide.
- Patients are assessed for suicide risk upon admission, annually, change in functioning level, before therapeutic/court passes, treatment plan updates, and at time of discharge.
- A Crisis hotline number is given to the patient and family members at the time of pass/discharge.
- CLSH conducts an annual risk assessment to identify environmental features that may increase the risk of suicide.

****The NPSG are available in binders on each unit and the CLSH***

intranet for more details.

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Goal 1

Improve the accuracy of patient identification.

NPSG .01.01.01: Use at least two patient identifiers when providing care, treatment, and services.

Rationale for NPSG .01.01.01

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.

Elements of Performance for NPSG .01.01.01

1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples, and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM .05.01.09, EPs 8 and 11; NPSG .01.03.01 EP 1).
2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG .01.03.01 EP 1)

Goal 2

Improve the effectiveness of communication among caregivers.

NPSG .02.03.01: Report critical results of tests and diagnostic procedures on a timely basis

Rationale for NPSG .02.03.01

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

Elements of Performance for NPSG .02.03.01

3. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
 - The definition of critical results of tests and diagnostic procedures
 - By whom and to whom critical results of test and diagnostic procedures are reported

- The acceptable length of time between the availability and reporting of critical results of test and diagnostic procedures.
 1. Implement the procedures for managing the critical results of test and diagnostic procedures.
 2. Evaluate the timeliness of reporting the critical results of test and diagnostic procedures.

Goal 3

Improve the safety of using medications.

NPSG .03.04.01: Label all medications, medication container, and other solutions on and off the sterile field in the perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins.

Rationale for NPSG .03.04.01

Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of safe medication management, yet it is routine in many organizations. The labeling of all medications, medication containers, and solutions is a risk reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09

Elements of Performance for NPSG .03.04.01

3. In the perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Refer to NPSG.03.04.01, EP5, for information on timing of labeling.

1. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.
2. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:

- Medication name
- Strength

- Quantity
 - Diluent and volume (if not apparent from the container)
 - Preparation date
 - Expiration date when not used within 24 hours
 - Expiration time when expiration occurs in less than 24 hours
 - Note the date and times are not necessary for short procedures, as defined by the hospital.
3. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
 1. Label each medication or solution as soon as it is prepared, unless it is immediately administered. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
 2. Immediately discard any medication or solution found unlabeled.
 3. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure. Note: This does not apply to multiuse vials that are handled according to infection control practices.
 4. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.

NPSG .03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Rationale for NPSG .03.05.01

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular international Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG .03.05.01

5. Uses only oral unit-dose products, pre-filled syringes, or pre-mixed infusion bags when these types of products are available. Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.

1. Use approved protocols for the initiation and maintenance of anticoagulant therapy.

2. Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.

3. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.

4. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.

5. A written policy addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.

6. Provide education regarding anticoagulant therapy to staff, patients, and families.

Patient/family education includes the following:

- The importance of follow-up monitoring
- Compliance
- Drug-food interactions
- The potential for adverse drug reactions and interactions

7. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization

Goal 7

Reduce the risk of health care-associated infections.

NPSG .07.01.01: *Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.*

Rationale for NPSG .07.01.01

According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization. Consequently, health care-associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene

policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.

Elements of Performance for NPSG .07.01.01

1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP5)

1. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 3)

2. Improve compliance with hand hygiene guidelines based on established goals.

NPSG .07.03.01: Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals. Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria..

Rationale for NPSG .07.03.01

Patients continue to acquire health care-associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care-associated infections from epidemiologically important multidrug-resistant organisms (MDROs). Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient's environment are essential strategies for preventing the spread of health care-associated infections. Hand hygiene is addressed in NPSG .07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC .02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC .02.02.01

Elements of Performance for NPSG .07.03.01

3. Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission. (See also IC .01.03.01, EPs 1-5)

1. Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care-associated infections, multi-drug resistant organisms, and prevention strategies at hire and annually thereafter. Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the hospital.
2. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care-associated infection strategies.
3. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment. Note: Surveillance may be targeted rather than hospital-wide.
 4. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
 - a. Multidrug-resistant organism infection rates using evidence-based metrics
 - b. Compliance with evidence-based guidelines or best practices
 - c. Evaluation of the education program provided to staff and licensed independent practitioners. Note: Surveillance may be targeted rather than hospital-wide.
 5. Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.
 1. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines.
 2. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms. Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.
 3. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms. Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both. Note 2: Each hospital may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.

Goal 8

Accurately and completely reconcile medications across the continuum of care.

NPSG .08.01.01: A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the hospital.

Rationale for Requirement .08.01.01

Patients are at high risk for harm from adverse drug events when communication about medications is not clear. The chance for communication errors increases whenever individuals involved in a patient's care change. Communicating about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.

Elements of Performance for NPSG .08.01.01

4. At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient and as needed, the family are involved in creating this list.

Note: This element of performance is not in effect at this time.

1. The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.

Note: This element of performance is not in effect at this time.

2. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital. Note: This element of performance is not in effect at this time.

3. When the patient's care is transferred within the hospital (for example, from the ICU to a floor), the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication.

Note: Updating the status of a patient's medications is also an important component of all patient care hand-offs. Note: This element of performance is not in effect at this time.

NPSG .08.02.01: When a patient is referred to or transferred from one hospital to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication documented. Alternatively, when a patient leaves the hospital's care to go directly to his or her home, the complete and reconciled list of medications is provided to the patient's known primary care provider, the original referring provider, or a known next provider of service. Note: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the patient and, as needed, the family the list of reconciled medications is sufficient.

Rationale for NPSG .08.02.01

The accurate communication of a patient's reconciled medication list to the next provider reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the patient's medications and to safely order/prescribe other medications that may be needed. This communication

is especially important at transitions in care when a patient is referred or transferred from one organization to another.

Elements of Performance for NPSG .08.02.01

4. The patient's most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented. Note: This element of performance is not in effect at this time.

1. At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications. Note: This element of performance is not in effect at this time.

NPSG .08.03.01: When a patient leaves the hospital's care, a complete and reconciled list of the patient's medications is provided directly to the patient and, as needed, the family, and the list is explained to the patient and/or family.

Rationale for NPSG .08.03.01

The accurate communication of the patient's medication list to the patient and, as needed, the family, reduces the risk of transition-related adverse drug events. A thorough knowledge of the patient's medications is essential for the patient's primary care provider or next provider of service to manage the subsequent stages of care for the patient.

Elements of Performance for NPSG .08.03.01

2. When the patient leaves the hospital's care, the current list of reconciled medications is provided and explained to the patient and, as needed, the family. This interaction is documented. Note: Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies. Note: This element of performance is not in effect at this time.

Goal 15

The organization identifies safety risks inherent in its patient population.

NPSG .15.01.01: The organization identifies patients at risk for suicide.

Rationale for NPSG .15.01.01

Suicide of a patient while in a staffed, round-the-clock setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the

care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Elements of Performance for NPSG .15.01.01

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
1. Address the patient's immediate safety needs and most appropriate setting for treatment.
2. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

NPSG .01.01.01

IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION

POLICY:

Accurate identification of the patient must be made prior to providing care, treatment, and services. A minimum of two patient identifiers must be used. The patient's room number or physical location is not used as an identifier.

When the purpose of photographing a patient is for identification, diagnosis or treatment and the patient refuses to give consent to be photographed, the treatment team can give authorization for the patient to be photographed. The photo is protected and confidential, as is the rest of the medical record. Policy requires their consent if the purpose is for other than identification, diagnosis or treatment.

CLSH will utilize the following two identifiers:

1. Patient photograph: A current patient photograph attached to the MAR or the current photograph in the patient record.
2. Patient name: Identification of the patient by name will occur prior to providing care, treatment, and services. Patients will also be identified by the Psychiatric Aide or another staff member who knows the patient (facial recognition).

PROCEDURE:

Medication

The patient's photograph placed in the MAR should be checked as the patient identifies him/herself for medication administration. A Psychiatric Aide familiar with the patient must also identify the patient by name.

Other Procedures

The patient's record containing a current photograph of the patient will accompany the patient at the time of procedure. The patient will be identified by name and by a psychiatric aide familiar with the patient prior to the procedure. Additionally, the individual performing the procedure will ask the patient his/her name and verify that the stated name matches the patient's record and photograph. Containers used for blood and other specimens are labeled in the presence of the patient.

NPSG .02.03.01

CRITICAL TESTS and RESULTS

POLICY:

Critical tests are not ordered at CLSH. Critical results are defined as the CLSH contract lab's panic values. Critical results of diagnostic procedures are defined as the performing facility's critical results.

PROCEDURE:

All critical lab values/diagnostic results will be called in, by the contract lab/performing facility within one hour of availability of results, to the Medical Clinic Staff during regular work hours and to the OD Nurse after hours and

weekends. Medical Clinic Staff/OD Nurse will then notify the treating physician and document this on the Lab 24 Hour Report. When a physician is called with a critical test result he/she has one hour to respond. If the treating physician is not available, the Medical Clinic Staff/OD Nurse will notify another privileged physician to respond.

Medical Clinic staff will collect the Lab 24 Hour Report from the OD Nurse each weekday morning at 6:00 a.m.

Medical Clinic staff will keep an accurate account of the reporting of critical results and the timeframes. A report will be submitted to the Utilization Review Committee and the Medical Executive Committee monthly. Corrective action is taken when appropriate.

*****SEE 24 HOUR LAB REPORT SHEET*****

NPSG .03.04.01

Labeling Medication

POLICY:

- CLSH's only procedural settings occur in the Dental Clinic.
- Medications and solutions are labeled on and off the sterile field even if there is only one medication being used.
- No medications will be transferred from the original packaging to another container. Only unit dose medication, which has been pre-labeled by the manufacturer with name, strength, amount and expiration date, is used in the Dental Clinic.
- All medication or solution labels must be verified both verbally and visually by
- The Dentist prepares and administers all medications in the Dental Clinic.
- Any medications or solutions found unlabeled are immediately discarded.
- Lot numbers of medications used are documented and kept in the Dental Clinic for reference.
- At the conclusion of the procedure all labeled medications on the sterile field are discarded.

NPSG .03.05.01

Anti-coagulation Policy

PURPOSE:

To reduce the likelihood of client harm associated with the use of anticoagulation therapy, and pursue optimal treatment outcomes for clients receiving anticoagulation treatment.

DEFINITIONS:

3. aPTT – Partial Thromboplastin Time, activated –a blood test used to determine the amount of time required for the clotting process in blood to occur.
1. INR – International Normalized Ratio- a blood test used to evaluate the ability of blood to clot properly. The test can used to assess both bleeding and clotting tendencies.
2. Warfarin/ (coumadin) An oral anticoagulant that inhibits the synthesis of clotting factors, thus preventing blood clot formation. It is metabolized by the liver and excreted by the kidneys.
3. Vitamin K- a fat soluble vitamin used by the body in the synthesis of several clotting factors, which are necessary for normal blood clotting to occur.

PROCEDURES:

A. Anticoagulant Protocol for the specific anticoagulant medication will be ordered at the time the anticoagulant therapy is prescribed. At the time the Anticoagulant Protocol order is written, the LIP will define the target range INR for the individual client. The nurse is responsible for notifying the LIP for out of target range results, pharmacy will receive a copy of all lab values reported and consult the LIP concerning any values out of the ordered range of the LIP.

B. When a client is prescribed Warfarin, the Unit Nurse will educate the client with respect to the importance of follow up monitoring, compliance, drug-food interactions, and the potential for adverse drug reactions and interactions.

A. Recommended monitoring guidelines are listed below, but are for reference only. The initiation and maintenance of anticoagulation will be at the discretion of the prescribing physician and will be maintained according to the directions of the treating physician.

Warfarin Monitoring Protocol:

Stage of warfarin anticoagulation therapy	Frequency of monitoring INR
Initially	Baseline INR (required)
Until therapeutic result is obtained, as determined by the LIP.	Every other day, including weekends and holidays
After anticoagulation has been stabilized, as determined by the LIP.	Weekly for 4 weeks, then every 2 weeks for 2 months, then monthly as long as on warfarin.

Recommendations for Warfarin Dose Adjustments and Follow-up Algorithms:

The dose will be individualized by the LIP.

Warfarin Target INR of 2.5 (Range 2.0 – 3.0)						
Client's INR	<1.5	1.5 – 1.9	2.0 – 3.0	3.1 – 3.9	4.0 – 4.9	>=5
Dose Change	Increase dose 10-20%. Consider extra dose.	Increase dose 5-10%	No Change in dose	Decrease dose 5-10%	Hold 0-2 days and decrease dose 10%	Critical - the prescriber or duty doctor should be notified and consulted for action.
Next INR	4-8 days	7-14 days	See follow-up algorithm below	7-14 days	4-8 days	

Warfarin Target INR of 3.0 (Range 2.5 – 3.5)						
Client's INR	<1.5	1.5 – 2.4	2.5 – 3.5	3.6 – 4.4	4.5 – 4.9	>=5
Dose Change	Increase dose 10-20%. Consider extra dose.	Increase dose 5-10%	No Change in dose	Decrease dose 5-10%. Consider holding 1 dose	Hold 0-1 day and decrease dose 10%	Critical - the prescriber or duty doctor should be notified and consulted for action.
Next INR	4-8 days	7-14 days	See follow-up algorithm below	7-14 days	4-7 days	

Follow – up Algorithm	
# of Consecutive In-range INRs	Repeat INR in:
1	5-10 days
2	2 weeks
3	3 weeks
4	4 weeks
If Target of 2.5 and INR 2.0 – 2.1 or 2.9 – 3.0	consider repeat INR in 2-3 weeks regardless of # of consecutive in range INRs
If Target of 3.0 and INR 2.5 – 2.6 or 3.4 – 3.5	consider repeat INR in 2-3 weeks regardless of # of consecutive in range INRs
For clients with many consecutive therapeutic INRs	the follow up algorithm may be accelerated for a single out of range INR

CRITICAL INR OF > 5.9 or current labs critical value		
<i>An INR of 5.9 or greater is considered critical, the prescriber or duty doctor should be notified and consulted for action.</i>		
INR Level	Client Does Not Have Risk Factors for	Client Has Risk Factors for Bleeding:

	Bleeding:	
INR >5 but <9 and no clinically significant bleeding	Omit the next dose or two of warfarin and monitor INR more closely. Once INR is therapeutic, resume lower dose per the adjustment table.	Give Vitamin K1 orally at a dose of 1 - 2.5 mg.
INR > 9 and no clinical bleeding.	Vitamin K1 orally at a dose of 3 – 5mg. Hold warfarin dose until INR is repeated in 24 – 48 hours. If still elevated, repeat Vitamin K1 dose.	Consider transfer to emergency room.
Any level, If life-threatening bleeding or serious warfarin overdose occurs	Client should be taken to the Emergency Room.	Client should be taken to the Emergency Room.

1. A baseline INR is required prior to initiation of therapy at Central Louisiana State Hospital.
2. The treating physician will determine the condition for which coumadin is prescribed and list the target INR and the ranges that INR is to be maintained.
3. The treating physician will determine and order the labs and frequency of lab draws and convey this information by writing a physician order and the Coumadin protocol.
4. The pharmacy will notify the dietician of a client for which coumadin has been prescribed.
5. The dietician will access, and monitor a dietary plan that is required while a patient is receiving coumadin.
6. Nursing staff will immediately notify the physician of any critical lab values including those affecting Coumadin therapy.
7. Pharmacy will consult with prescribing physician on any out of range lab values.
8. Pharmacy will monitor all medications written for clients on coumadin and consult with the prescribing physician prior to dispensing any medications which are listed as critical drug interactions with coumadin.
9. Coumadin orders will be listed on the monthly medications reviews with the following statement: Coumadin orders are written, and adjusted by the primary care physician only. The unit physician may renew standing orders for coumadin at the time of monthly medication reviews with the following statement added (per primary care physicians recommendations).
10. Coumadin orders will only be written by the primary care physician, medical director or the medical director's designee.

NPSG.07.01.01

CLSH will achieve and maintain 90% or greater compliance with hand hygiene guidelines. Hand hygiene compliance will be monitored and any negative trends will be reported in Quality Improvement Committee. Refer to Clinical Policy #77 for complete hand hygiene guidelines.

NPSG.07.03.01

Refer to Clinical Policy #94 for NPSG .07.03.01

NPSG .08.01.01, .08.02.01, .08.03.01

MEDICATION RECONCILIATION

POLICY:

Medication reconciliation is an ongoing process at CLSH. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.

The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of admission. Additionally, all medications are reviewed by the treating physician every 30 days.

ADMISSION PROCEDURE:

Upon admission to CLSH the admitting physician or the admitting OD Nurse will obtain a complete list of the patient's current medications, including the dose, route and frequency. The patient, and as needed, the family are involved in creating this list. These medications will be documented on the Medication Reconciliation Form. The admitting physician will determine the disposition of each medication at this time. Upon the patient's arrival to the unit, the treating psychiatrist will review the Medication Reconciliation Form and determine any further disposition of the meds (see Medication Reconciliation Form).

TRANSFER PROCEDURE:

When the patient's care is transferred within the hospital, the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication. At the time a patient is transferred to another service within CLSH (e.g. Adolescent to Adaptive Behavioral Service) the receiving unit physician shall do a complete "Medication Review" checking to make sure the list is accurate.

When a CLSH patient is transferred to another medical facility, the patient's most current reconciled medication list is communicated to the next provider of care. At the time of transfer, CLSH also informs the next provider of service on how to obtain clarification on the list of reconciled medications.

When a patient is transferred back to CLSH following a period of inpatient care at another medical facility, medication reconciliation will be done by conducting a complete medication review. The medication review process will begin immediately upon receipt of the patient in transfer. The patient will also be examined by a CLSH physician within 12 hours of transfer if possible, but in no case later than 24 hours. The CLSH physician will review the records from the transferring facility, examine the patient and document his findings in a progress note.

DISCHARGE PROCEDURE:

At the time of discharge the pharmacy sends two complete lists of the patient's current medications to the unit, one is the SOCIAL WORKER'S COPY and one is the PATIENT'S COPY. The Social Worker for the patient will then fax this list to the next provider of care outside the organization. The Unit RN will give the patient, and as needed the family, his/her copy of the medication list along with an explanation, at the time of discharge. The patient and family are also reminded to discard old medication lists and to update any records with all medication providers or retail pharmacies at this time. Verification of this process will be documented in the progress notes of the patient's chart.

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*****SEE MEDICATION RECONCILIATION FORM*****

NPSG .15.01.01

SAFETY RISKS

POLICY

The hospital identifies patients at risk for suicide.

PROCEDURE:

At admission, an assessment of risk must be performed by the admitting physician, on all patients, as part of the initial psychiatric evaluation and a risk assessment form completed by that physician.

Reassessment of risk will be done by the treating physician and a risk assessment note completed prior to passes, discharge, court hearings and certain levels changes, as required by Clinical Policy #3. This process will also take place at the Master Treatment Plan and subsequent treatment plan update staff meetings.

If a patient is placed on precautions for a self-harm incident, or for protection of self from self harm, a risk assessment will be included in the physician's first daily note and thereafter as clinically appropriate.

When high risk behaviors are identified, appropriate protective measures and changes to the treatment plan must be considered and rationales documented in the patient's record to assure both patient and community safety.

The hospital provides a crisis hotline number to patients and their family members. The crisis hotline number is documented on the back of the patient's copy of the Discharge Certificate (#1-31-23) and the Pass Certificate (#1-31-14). This information can also be obtained in the Patient/Family Handbook.

A risk assessment for environmental features that may increase or decrease the risk of suicide has been conducted by the CLSH Safety Officer and will be re-conducted as necessary. This information is made available to the appropriate staff.

4-41-61 (Rev.11/08)

CENTRAL LOUISIANA STATE HOSPITAL RISK ASSESSMENT

PATIENT NAME: _____ CLSH # _____

- A. Violence: History of Dangerous Behavior (Juvenile and Adult)
- ___ 1. Juvenile history of dangerous felony or violence.
 - ___ 2. Adult history of dangerous felony or violence especially if history of substance abuse.
- B. Violence: Diagnosis and Mental Status
- ___ 1. Psychosis, cognitive disturbance, agitation, hostility, anxiety.
 - ___ 2. Personality disorder (especially antisocial) or developmental disability.
- A. Violence: Stressors, Means to Violence
- ___ 1. Current or recent violent fantasies and ruminations indicate a potential for violence.
 - ___ 2. Current anger, stress or threats of harming others in ways that can be carried out.
- A. Self-harm or Suicide
- ___ 1. History of suicide attempts or self-injury.
 - ___ 2. Physical illness or recent loss, increasing risk of suicide.
 - ___ 3. Personality or developmental disorder (Axis II) leading to risk of self-injury.
 - ___ 4. Adolescent or elderly, male, Caucasian
 - ___ 5. Threats to harm self or suicidal ideation or plan, or behavioral indicators of risk
 - ___ 6. Current lack of feelings of support. Presence of hopelessness, discouragement, anxiety.

A. Elopement

- ___ 1. Personality factors leading to elopement risk (for example, uncooperative, unpredictable, antisocial)
- ___ 2. History of elopement from hospitals.
- ___ 3. Legal status indicating elopement risk (criminal court or other involuntary commitment).
- ___ 4. Current impulsivity leading to elopement risk or current threats to elope.
- ___ 5. Recent elopement or attempts to elope.
- ___ 6. Presence of hopelessness, discouragement, anxiety.

A. Mental Disorder

- ___ 1. Current active disorder predisposing to acting out (cognitive deficit, psychosis, depression, anxiety).
- ___ 2. Previous violence, self-injury or suicide attempt or elopement linked with mental disorder.
- ___ 3. Anger, psychosis, anxiety, depression, argumentative behavior due to current disorder.

RISK SUMMARY: (5 highest, 1 lowest or none)

Self-injury	1	2	3	4	5	Violence	1	2	3	4	5	Elopement	1	2	3	4	5
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Ameliorating Factors, Analysis or Plan (for example, problems noted are not current, treatment has lessened risk, condition now more stable and whether special precautions are needed):

Calming influences as described by patient or family:

Methods of restoring control when upset or angry (techniques, methods or tools that would help the patient control his or her behavior and thus reduce the need for restraint use, especially for patients at high or moderate risk; behavioral approach to patient):

Physician's Signature

Date

**CENTRAL LOUISIANA STATE HOSPITAL
Pineville, Louisiana**

Universal Protocol

ADA Recommendation

The American Dental Association (ADA) has been very supportive of efforts to eliminate wrong site surgery, including wrong dental extractions. However, the ADA acknowledges that there does not appear to be a practical or reliable method to actually mark the teeth that are intended for extraction. Therefore, dental procedures will be considered exempt from the site-marking requirement. In lieu of directly marking the teeth, the ADA recommends—and the Joint Commission concurs with—the following:

- Review the dental record including the medical history, laboratory findings, appropriate charts and dental radiographs. Indicate the tooth number(s) or mark the tooth site or surgical site on the diagram or radiograph to be included as part of the patient record.
- Ensure that radiographs are properly oriented and visually confirm that the correct teeth or tissues have been charted.
- Conduct a "time out" to verify patient, tooth and procedure with assistant present at the time of the extraction (two person rule).

State & Psychiatric) Hospital Compliance Collaborative
www.SPHCC.net

LAB 24-HOUR REPORT

*(4 p.m. – 4 p.m.)

DATE: _____

OD NURSE/LAB STAFF: 7/3 _____

OD NURSE: 3/11 _____ 11/7 _____

CRITICAL LAB/DIAGNOSTIC VALUES

PATIENT NAME	UNIT	Critical lab/diagnostic result reported:	Staff who received the lab results:	Time rec'd:	Name of physician	DATE/TIME PHYSICIAN REC'D RESULTS
Ex. John Doe	99	Potassium 6.0	Jane Doe, R.N.	1:00 p.m.	Dr. Lee	11/10/09 @ 1:20

O.D. Nurse will begin a new 24-hour report each day at 4 p.m. Lab staff will collect the report each weekday at 6:00 a.m.

