مستشفى المواساة الجديد
NEW MOWASAT HOSPITAL

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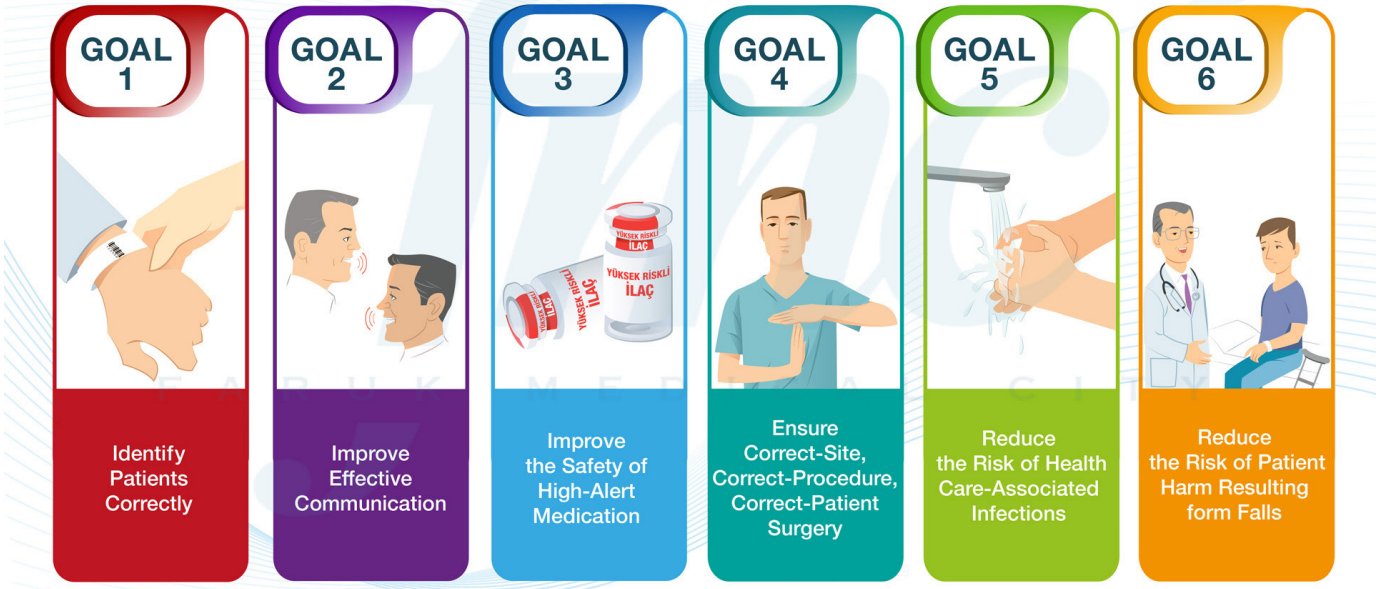
NMH QUALITY NEWSLETTER

Greetings everyone! Welcome to our inaugural issue and this will be published monthly. Our endeavor is to keep you updated about news, quality assurance, patient safety, and risk -management and also invite contributions from all of you.☺

PATIENT SAFETY GOALS



(ACI) Accreditation Canada International

(JCI) Joint Commission International

Goal 1: Identify Patient Correctly

Wrong-patient errors occur in all aspects of diagnosis and treatment.

Patients may be sedated, disoriented, or not fully alert; may change beds, rooms, or locations within the hospital; may have sensory disabilities; or may be subject to other situations that may lead to errors in correct Identification.

- ✔ Patients are identified using TWO PATIENT IDENTIFIERS
- ✔ NEVER USE patient room number or bed number as identifiers
- ✔ Patients are identified BEFORE:
  - Providing treatments and procedures e.g administering medication, blood, serving a restricted diet tray, insertion of intravenous line
  - Any diagnostic procedures such as taking blood & other specimen for clinical testing, performing diagnostic radiology procedure

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Incident Reporting

Patient Safety
Incidents include

1. Near Miss:
An incident that did not reach the patient.

2. No Harm Event:
An incident that reached a patient but no discernible harm caused.

3. Adverse Event:
An incident that resulted in harm to a patient.

NEARMISS IS A WAKE UP CALL. IT COULD BE THE NEXT ACCIDENT! DO NOT IGNORE IT

REPORT IT

All NMH Staffs are encouraged to report any Near miss & adverse occurrence by filling HMIS ONLINE AOR FORM

Patient Confidentiality & Privacy

DO'S & DON'TS

- ✓ Only authorized individual are permitted to access either medical records or electronic records.
- ✓ Log-out after using computers in patient care areas.
- ✓ Close door and curtains during treatment and examination
- ✓ Cover patients appropriately during treatment and transport.
- ✓ Modulate voice volume in areas where privacy could be compromised.
- ✗ Share computers passwords.
- ✗ Discuss patient-specific information in public areas like lift, corridors, cafeterias and hallways.
- ✗ Display patient-specific information on notice boards accessible to the public.
- ✗ Hand-over patient's medical record to patient/family during patient's transportation from one area to another.
- ✗ Leave medical records or case notes in public areas or unattended by staff.

LET'S TAKE A QUIZ – DON'T GIVE UP SO EASILY

HURRY UP!

Submit your answer to QSM office. NAMES OF FIRST 3 CORRECT SUBMISSION will be published in next issue and WIN a token of appreciation. CHECK THE ANSWER IN NEXT ISSUE.

1. Should two patient identifiers be the same/consistent always?
A) Yes B) No

2. Is the term critical test results limited to laboratory tests?
A) Yes B) No

3. Whenever a nurse takes a telephone or verbal order in hospital, he or she must repeat it back to the physician to confirm that it was understood correctly. Is this acceptable?
A) Yes B) No

4. What is correct for sentinel event?
A) Unanticipated occurrence involving death or serious physical or psychological injury
B) Death unrelated to the natural course of the patient's illness
C) Wrong-site, wrong-procedure, wrong-patient surgery
D) Event signaling the need for immediate investigation and response

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SUBMISSION CALL for Award Winning
Dept. Quality Improvement Project

QSM Office invites you all to share your departmental success stories, motivational & educational anecdotes, events & activities related to performance improvement, patient safety, risk management & accreditation.
Submissions deadline for next issue: 11th August 2016.
Mail to:ssheikh@newmowasat.com

"It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm."
Florence Nightingale