- Be assure that you understand all discharge medication orders.
- Make sure all your questions are answered.

Hospital Survey

After your hospital stay at Abington Memorial Hospital, you may receive a patient survey in the mail. We encourage you to complete the survey and provide honest feedback about your hospital experience. Helping to identify areas of improvement or acknowledging positive experiences is another way you can become a partner in your health care.

TO TOP OF PAGE

PATIENT SAFETY AT ABINGTON MEMORIAL HOSPITAL

Abington Memorial Hospital has always been committed to providing a safe environment for patients. The Institute of Medicine report in December 1999, "To Err is Human: Building a Safer Health System," notes that 60 to 70 percent of medication errors can be prevented by building safeguards into hospital systems. This is a call to action for renewal of our fundamental pledge to patient safety. Therefore, in early 2000, a Patient Safety Peer Review Committee was established to identify and reduce any preventable medical errors. Three significant steps have been implemented to improve patient safety including:

Computerized Physician Order Entry

Abington Memorial Hospital is proud to announce that it has achieved computerized physician order entry within the hospital. This first initiative was an enormous step in patient safety as medical literature suggests the potential for reducing hospital medication errors by 40 to 90 percent through this one change. In attaining this goal, illegible handwriting is eliminated, medical errors are reduced and patient care is improved.

Safety Assurance Report

Abington Memorial Hospital has instituted a blame-free safety assurance reporting form for all employees and physicians at Abington Memorial Hospital. Recognizing that human error is a fact of life, incidents will occur. The best remedy is to not let such incidents be repeated. Every employee is personally responsible for preventing and reporting any potential hazard or risk. The Safety Assurance Report helps the hospital to better identify, track and trend areas or systems that may need improvements.

Patient Safety Newsletter

Abington Memorial Hospital produces and distributes a hospital-wide patient safety newsletter that chronicles all of the hospital's patient safety initiatives and accomplishments as well as case studies that offer insights on patient safety issues. The newsletter serves as both an educational tool as well as a communication vehicle to discuss various aspects of patient safety.

Continuing to Plan for the Future

These are only the first steps in a never-ending journey to improve patient safety. Each year, Abington Memorial

Hospital will develop new patient safety goals as we strive to revamp our systems and deploy new technologies to reduce and prevent medical errors.

Abington Memorial Hospital's initiatives include:

- Installation of a new clinical information system
- Installation of a new pharmacy computer system
- New safety initiatives for laboratory, radiology and Emergency Trauma Center services
- Ongoing education for medical and nursing staff
- Deployment of a patient safety officer on inpatient nursing units

TO TOP OF PAGE

MORE PATIENT SAFETY INFORMATION

For additional information on patient safety, visit these web sites.

- National Council on Patient Information and Education at <u>www.talkaboutrx.org</u>
- American Hospital Association at www.aha.org/medicationsafety

For additional information on patient safety, a free brochure is available by contacting Abington Memorial Hospital's Patient Safety Office at (215) 481-2209.

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University Hospital and Manhattan Campus for the Albert Einstein College of Medicine

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Medication Safety and You

It is important for you to take an active role in your health care. this is a list of things you should know about your medications:

- What is the name of the medication I am taking?
- What is my prescription used for?
- How long should I take it?
- What side effects can I expect?
- Are there any special instructions I should observe while I am taking this medication?
- Are there any foods, herbal supplements, medications or over the counter medications I should avoid?
- If I'm taking several medications, are there any potential interactions I should be aware of?

If you have any questions, be sure to ask your physician, nurse or pharmacist.

Use the back for notes...



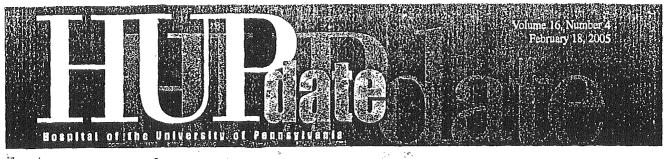


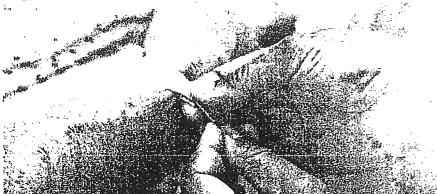






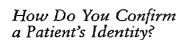






PATIENT IDENTIFICATION:

us Everyone's Job!



LIZA SEVERANCE-LOSSIN, NURSE ON SILVERSTEIN 12

"We receive patients from many areas – the OR, PACU, ICU, direct admits, transfers. If patients are able to talk when they arrive, we'll ask their name and date of birth, and will check it against both the nursing worksheets and their wristband. If the patient is unable to speak, we'll check the infor-

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mation on the wristband against the worksheet. We never use the room number to ID a patient. Every time we have an interaction with a patient, we ask the patient's name and date of birth. After a while, some patients will tell me without my asking!"

Liza Severence-Lossin verifies
patient identifiers with transporter Torrence Adams

One of HUP's most important responsibilities is to ensure the safety of its patients. Through many intitiatives over the past few years — such as PORTS (Penn Occurrence Reporting and Tracking System), the Delta Team, and Failure Mode Effects Analysis and Root Cause Analysis — we have continued to strengthen our patient safety efforts. Now, a new initiative is focusing on a key — and simple — component of that responsibility: making sure patients are properly identified from the time they register to their discharge.

"Positively identifying the patient is the primary basis for providing quality care," stressed HUP Executive Director Garry Scheib. "It must be part of every patient encounter, and it must continue until he or she is discharged."

"The overall goal of the Patient Identification Program is to provide the right care to the right person at the right time," agreed P.J. Brennan, MD, chief of Healthcare Quality and Patient Safety. "It emphasizes pinpoint accuracy."

Two Distinct Identifiers

A common last name in a phone directory often has multiple entries — many with the same first name. In HUP's IDX system — which contains nearly three million patient records — it's not uncommon to see two or more patients with the same last name. While calling the wrong John Smith will probably have no detrimental effect, treating the wrong John Smith could lead to potentially serious results.

According to Maryellen Reilly, associate executive director of Access and Transition, a senior leadership task force was formed to examine patient identification compliance and it developed several strategies to improve compliance. For example, Admissions implemented an identification auditing process which provides weekly feedback to the Nursing units with good results.

Another strategy standardized identifiers as name and date of birth. As Reilly stressed, "Employees should never begin treatment for a patient without validating both pieces of this information."

(continued on page 2)

Ⅲ. 健康危機情報

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IV. 研究成果の刊行に関する一覧表

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V. 研究成果の刊行物·別刷

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VI. 研究成果による特許権等の知的財産権の出願・登録状況

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