

Patient Rights

Portneuf Medical Center 2011

PORTNEUF'S COMMITMENT

- Portneuf Medical Center encourages respect for the personal preferences and values of each individual and supports the rights of each patient and resident of the center or their representative.

PORTNEUF'S COMMITMENT

- Patient centered care
- Providing clear and concise information and education to patient and their families
- Providing help and answers to patient and family questions

KNOW THE RIGHTS

- The right to considerate and respectful care
- The right to ask for and receive relevant, current, and understandable information
- The right to consent or to refuse a treatment
- The right to have an Advanced Directive and to have the intent honored
- The right to pain management
- The right to privacy
- The right to records
- The right to review records
- The right to available services or transfer
- The right to information on business relationships
- The right to consent to or refuse research studies
- The right to care alternatives
- The right to grievance policies and resolving concerns

INFORMED CONSENT

- Can only be obtained by an Licensed Independent Practitioner (LIP)
 - Patient
 - Spouse
 - Parent
 - Child
 - Minor Consent
- Refusal of Consent

INFORMED CONSENT (Cont)

- Risks
- Benefits
- Alternatives
- And state agreement to proceed
- Must be taught in a manner that the patient can understand.

WHERE TO GET PATIENT RIGHTS

- Copies of Patient Rights are located in the following locations:
 - In the Patient Guide offered to EVERY patient at admissions
 - In the Patient Room Guide in every patient room
 - Posted in prominent places in outpatient areas
 - On the I-Net forms repository form BR00013 and BR00049

STAFF RESPONSIBILITY

- It is the responsibility of every member of the PMC team to:
 - Know the patient rights
 - Educate the patient on their rights
 - Document that the steps you take to make sure that every patient is treated according to the patient rights
 - Document all education and consent related to every patient.

INCIDENT REPORTING

PURPOSE

- Documentation of unusual events
- Improve Patient Care
- Improve Patient Safety
- Non-discoverable documentation of events

WHAT TO REPORT

If you scratch your head and go...that was weird, strange, or unusual...

**You need to fill out an
incident report!!!**

WHAT TO REPORT

- Medication Errors
 - Missed doses
 - Late doses
 - Wrong time
 - Wrong dose
 - Wrong patient
 - Wrong route
 - Narcotic count errors



WHAT TO REPORT

- Procedure Events
 - Missed procedure, eg monitoring, vitals, treatment
 - Wrong OR count
 - Wrong procedure
 - Surgical complication
 - Unanticipated Outcomes

WHAT TO REPORT

- FALLS
 - Found on floor
 - Slip, trip
 - From bed
 - From chair
 - From commode
 - While assisted



WHAT TO REPORT

- INTERPERSONAL ISSUES
 - Physician or staff misconduct
 - Family or visitor misconduct
 - Physician complaints

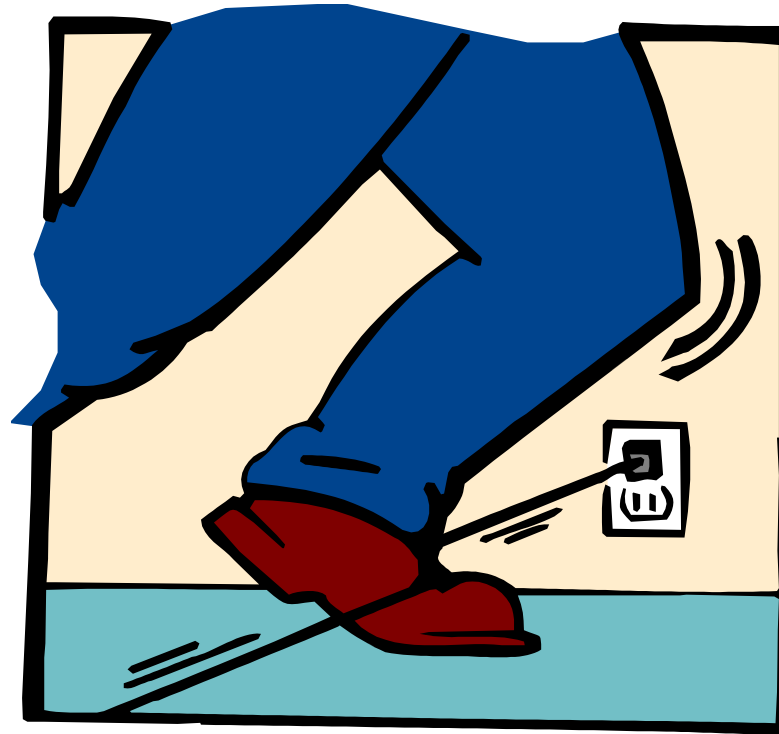


PHYSICIAN HOTLINE

- For physicians to report any issue to administration – through the dictation system

WHAT NOT TO REPORT

- Employee injuries are reported on an Employee Injury Illness form and sent to Employee Health



**Anything
else is fair
game...**

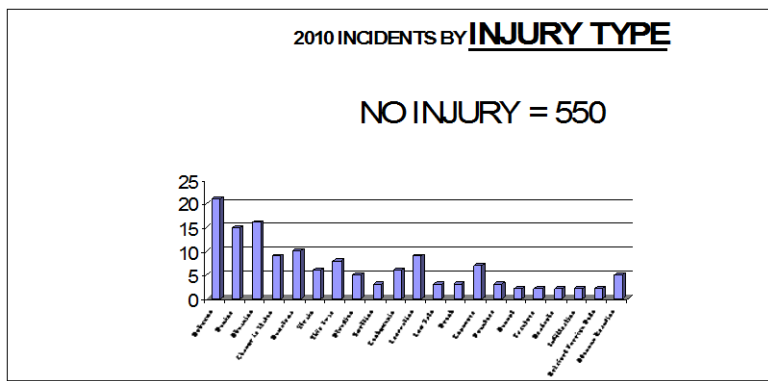
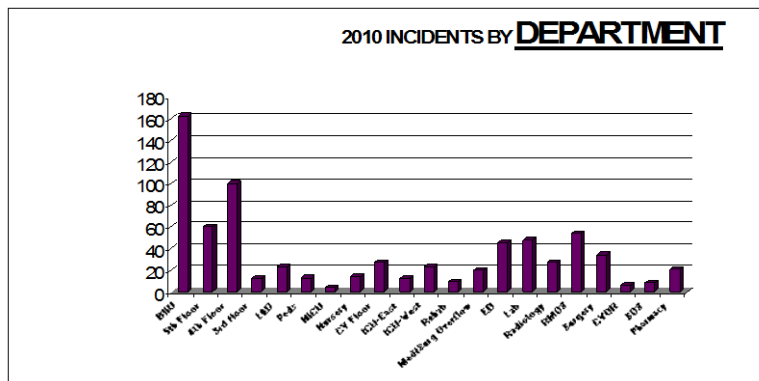
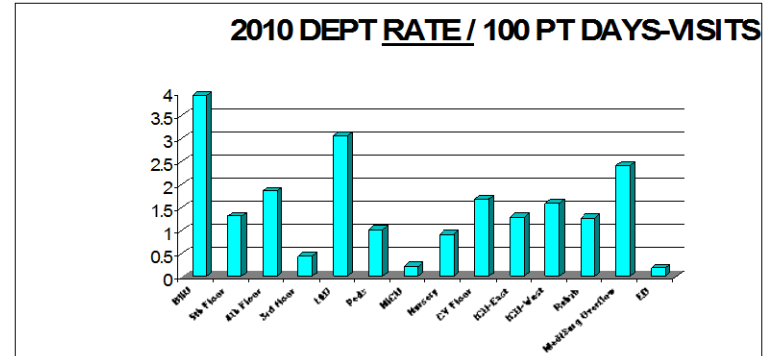
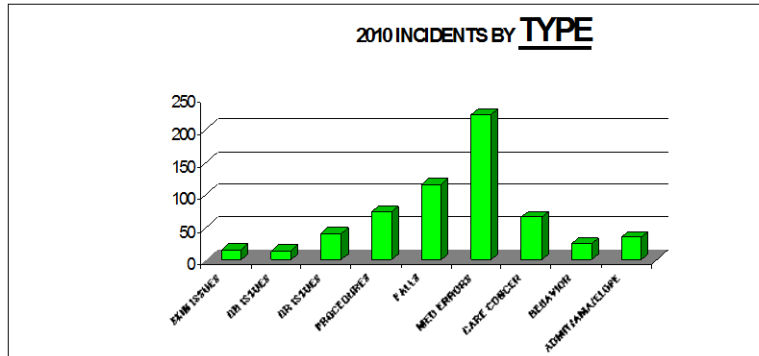
WHAT HAPPENS TO THE REPORTS

- Each Report is:
 - Reviewed by manager for resolution and documentation of actions taken
 - Reviewed by Quality and Risk for issues needing intervention
 - Entered into a data system for tracking and trending
 - Compiled into monthly reports for departments

REPORTS

- Monthly reports e-mailed to each manager
- Monthly reports posted to x: drive for managers
- Quarterly stats on med errors and falls reported to committees

REPORTS



MEDICATION SAFETY WATCH PROGRAM

- **PURPOSE**
 - To provide guidelines to ensure patient medication and allergies are reconciled and that medications are administered safely in the organization

POLICY

- All patients will have a current comprehensive list of allergies available to all providers of care.
- All patient allergies will be listed and reconciled with all sources on all admissions.
- All medications will be reconciled with the patient allergies on each admission through multiple sources and as the patient allergy status and medication orders change.
- All nursing will complete a reconciliation of each patient allergies and medication on each admission
- All nursing units will complete a daily audit of the compliance with the Allergy and Medication Reconciliation Audit
- Pharmacy will not override any medication without documentation on the patient chart of the clarification with the patient's physician regarding the override.
- All discrepancies found in the audit will be clarified with the physician and documented in the patient chart prior to administration of any medication on the allergy list.

PROCEDURE

- All allergies to be reconciled across the following sources
 - patient interview
 - H&P
 - IBEX
 - Paragon Admit history profile
 - MAR
 - CPN – L&D EMR
 - Outpatient Pharmacy
 - Transferring facility
 - Chart sticker
 - armband

ORDERS

- A valid out-patient order must have:
 - Patient name
 - Date
 - Diagnosis, sign or symptom
 - Procedure to be performed
 - LIP/Provider signature
- A valid in-patient order must have:
 - Patient name
 - Date and time order
 - LIP/Provider signature

CONCLUSION

- The only way that we can fix what may be wrong, is if we know about it
- Reports help us can track and trend where and how the fixed need to occur.
- The only way to improve safety is to know our vulnerabilities
- The only way to protect our self from liability is to have the documentation

- DOCUMENT, DOCUMENT, DOCUMENT

- REPORT, REPORT, REPORT

- YOU ARE THE EYES AND EARS OF THIS ORGANIZATION

THANKS FOR YOUR HELP IN MAKING US BETTER AND SAFER!!!!