



**New Mexico
Hospital Association**

Happy Holidays

Patient Safety Newsletter

Sin Daño – Without Harm

December 2007



INSIDE THIS ISSUE

PAGE:

1. IHI Visits Holy Cross in Taos

NMHA Statement on Transparency of Hospital Quality and Pricing

2. BROWN BAG TOPICS

- o Appoint a Safety Champion
- o Quiz on RRTs

Just Culture Checklist

Massachusetts Hospitals Publish Falls Data

3. TOOLS YOU CAN USE

The Safety Corridor E-library



IHI VISITS HOLY CROSS HOSPITAL

On Oct. 29, 2007, the Institute for Healthcare Improvement (IHI) honored Holy Cross Hospital (HCH) for its continuous quality improvements in patient safety by visiting the Taos hospital to learn how it has been successful. Holy Cross was the only hospital in New Mexico to host IHI. The HCH leadership team presented information about the LifeWings program, which uses aviation safety practices in hospital settings. Success stories from departments where LifeWings has been

introduced were highlighted. Hospital staff stressed that involvement by the Board of Directors and its physicians contribute to the program's success. The use of tools such as checklists, briefings and debriefings were discussed. The "**See it, Say it, Fix it!**" motto was explained. Staff also discussed efforts related to the Campaign's interventions, such as reducing infection by implementing scientifically proven infection control practices. Hospital-acquired infection due to MRSA has not occurred at the

hospital since 2005. Isolation, hand washing, and environmental cleaning strategies have contributed to this success. Additional in-depth discussion by the group involved other Campaign interventions and how the 49-bed, non-profit hospital has implemented them. As the campaign Node for NM, NMHA and NMMRA encourage hospitals to share information related to the campaign, and to highlight successes and lessons learned.

NEW MEXICO HOSPITAL ASSOCIATION BOARD ENDORSES TRANSPARENCY IN HOSPITAL QUALITY AND PRICING

The NMHA Board endorsed a statement on **Transparency in Reporting** at their November 14, 2007 Board meeting. This includes recommendations from the House Joint Memorial 67 (HJM 67) Task Force on Voluntary Reporting of Healthcare Associated Infections (HAIs). NMHA supports the transparent reporting of hospital quality and pricing data – including nosocomial infection rates - and will work to develop and implement a cost effective and reasonable reporting process for hospitals.

Recommendation:

1. Support the HJM 67 recommendation.
2. Encourage active participation by members in NHSN (Center for Disease Control National Healthcare Safety Network).
3. Adopt a proactive policy statement on transparency.

Recommendations of the HJM 67 Task Force

- A multi-disciplinary Advisory Committee will develop methods for

collecting, analyzing and disseminating information provided by participating healthcare facilities.

- The first year of HAI surveillance should be conducted as a pilot. Participation in the pilot should be voluntary, confidential and not reported publicly. NMHA will encourage members to participate in the pilot. All results should be reviewed by the Committee.
- The initial pilot year should collect data on **two** measures. The task force recommends **central line-associated bloodstream infections (CLABSIs) in adult intensive-care units** and **influenza vaccination rates of healthcare workers.**
- The pilot year outcomes should be assessed before further recommendations are provided.
- New Mexico's approach to HAI surveillance and public reporting should be aligned with ongoing national development of systems and associated

recommendations.

- All information that is ultimately publicly reported should be risk-adjusted.
- Participation in HAI surveillance should never violate a patient's right to confidentiality.
- Reporters of data should not be held liable by any party.
- An analysis should be conducted to estimate the current economic burden of HAIs in acute care hospitals in NM.
- Consumer preferences for how they want to obtain the data are taken into consideration when designing public reports. Education about the meaning of those reports should be included.
- NMDOH should be funded for implementation of the proposed pilot year, which would include technical assistance to participating hospitals, data monitoring and management, facilitation of the Advisory Committee, and assessment of the pilot year outcomes.



In the October 2007 issue of Nursing Management, a **Just Culture** checklist is available to assist organizations in becoming fair, accusation-free environments.

Strategies include:

- ✓ Work on fixing the system, not the person.
- ✓ Make expectations clear.
- ✓ Work to mitigate risk, such as fatigue, distractions, overload, and complexity.
- ✓ Use coaching to correct knowledge deficit and risky behaviors.
- ✓ Remember that neither people nor systems are perfect.
- ✓ Consider why rules may be broken – maybe they're bad rules or there's pressure to work around the rule.
- ✓ Ensure solid orientation for staff.
- ✓ Be vigilant for system weaknesses.
- ✓ Use errors as a learning experience.
- ✓ Talk about patient safety at every staff meeting.
- ✓ Always involve staff before making changes.
- ✓ Measure it.
- ✓ Emphasize that safety is EVERYONE'S job.

Additional information on **Just Culture** is available on the NMHA website www.nmhanet.org

STAFF MEETINGS – BROWN BAG TOPICS

- **Appoint a Safety Champion for Every Unit**
- **Quiz on Rapid Response Teams**

Communicating information about patient safety is an important responsibility that should not always fall to managers alone. It is often better to have a staff member in this role. Having a designated safety champion in every department and patient care unit demonstrates the organization's commitment to safety and may make other staff members feel more comfortable about sharing information and asking questions. Champions must have proper training, resources, and authority.

TIPS

- Seek volunteers from the staff; don't assign the task to a reluctant staff member.
- Give the safety champion the power to come up with quick solutions to certain problems, such as getting equipment fixed or replaced.
- Remind staff members that the safety champion is their ally, not an informer or a disciplinarian.
- Train the safety champion in safety concepts such as Human Factors Engineering—the science of why people make mistakes.
- Bring safety champions from different units together regularly to share information.
- Check with staff members occasionally to see how well the safety champion is meeting their needs.

What are three characteristics of a rapid response team? *Answer on Page 3.*

- A. The team will respond to calls within five minutes, the team will collaborate with the primary patient care team to provide support and education, and the team will initiate protocols as defined.
- B. The team will respond to calls when it is next available, the team will keep its findings as private for its own use, and the team will make a point to discuss findings with family members.
- C. The team will respond to calls within 30 minutes, the team will be available for questions after it has responded, and the team will take drastic measures, if necessary.
- D. The team will respond to calls within one hour, the team will provide privacy if the family requests it, and the team will let the patient's doctor make any decisions regarding the patient's health.

MASSACHUSETTS ACUTE-CARE HOSPITALS POST DATA ON FALLS

According to a Boston Globe article in October, 2007, the state's 70 acute-care hospitals reported 4,573 patient falls from October 2006 through March of this year, including 1,005 in which patients were injured, according to data being posted on the Massachusetts Hospital Association's website. The number of falls at individual hospitals, a key patient safety measure, varies widely, according to information posted on the website, patientsfirstma.org. Massachusetts is one of the first states where the information for each hospital is being made public. The website also contains fall data for nine rehabilitation and long-term-care hospitals.

"When you publish data, you're showing that you're willing to be held accountable," said James Conway, a senior vice president at the Institute for Healthcare Improvement. "You also drive improvement and begin to educate people so they can make better decisions." He said insurers and employers are studying this type of data so they can take into account a hospital's safety record when they negotiate payment rates.

Patient-safety specialists believe many falls can be prevented through better monitoring by nursing staff and more education of patients to ask for help getting out of bed. And Medicare will stop paying hospitals for treating complications from falls beginning next year. Several states plan to require hospitals to publicly report how often patients fall. The Massachusetts program is voluntary, but the hospital organization said that all acute-care hospitals have agreed to release the information.

The full article can be found at <http://www.boston.com/news/local/articles/2007/10/15/>



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Please contact us if you'd like to write an article or be interviewed for this newsletter that highlights Patient Safety efforts in your organization.

About Our Organization...

NMHA is the non-profit trade organization representing the 41 non-federal hospitals in the state.

Our mission is to work with others to improve the health status of the citizens of New Mexico



**New Mexico
 Hospital Association**

TOOLS YOU CAN USE
THE SAFETY CORRIDOR E-LIBRARY
TAKE ADVANTAGE OF FREE RESOURCES

Emergency Preparedness Atlas

The Agency for Healthcare Research and Quality has produced an atlas to help disaster planners locate hospitals and nursing homes that could assist in an emergency. It includes maps showing the location of hospitals and nursing homes in each state, case studies that show bed capacity and emergency management and bioterrorism preparedness regions. You can download from the AHRQ website:

<http://www.ahrq.gov/prep/nursinghomes/atlas/index.html>

Your Role in Safe Medication Use

The Massachusetts Coalition for the Prevention of Medical Errors has developed a consumer guide that encourages patients to become "part of the health care team" along with their physicians, nurses, and pharmacists, to prevent medication mistakes. The guide was developed in conjunction with the Washington, D.C.-based Institute for Family-Centered Care and is based on input solicited from patients, families, and health care professionals. The brochure is also available in Spanish. You can download English and Spanish versions at: <http://www.macoalition.org/index.shtml>

New Tools Help Pharmacies Better Serve Patients with Limited Health Literacy

To help pharmacies provide better quality services to people with limited health literacy, the U.S. Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ) announced two new resources, an assessment tool and training program. According to AHRQ, studies have found that people with limited health literacy are 12 to 18 times more likely to be unable to identify their own medications and distinguish them from one another than people who are more health literate. They also have difficulty understanding simple instructions, such as taking a medication every six hours, or how their medications work. For more information go to:

<http://www.ahrq.gov/browse/hlitix.htm>

THOUGHT FOR THE MONTH:

Leaders exist at all levels of the organization

Empower your teams to make decisions, drive processes and take risks. You will witness people at all levels within the organization stepping up to be accountable and to lead their colleagues when it is their time to take responsibility.

What are three characteristics of a Rapid Response Team? Answer is A) The team will respond to calls within five minutes, the team will collaborate with the primary patient care team to provide support and education, and the team will initiate protocols as defined.

TOOLKIT RESOURCES

Transforming the organizational culture is critical to improving patient safety. There is a positive trend of providers focusing on learning from past mistakes rather than pointing the finger when something goes wrong. Components of a safe culture include:

- Patient Safety Dialogues
- Blameless Reporting
- Engaged Leadership

To read some of the most recent articles, go to:

The end of the beginning: patient safety five years after 'To Err Is Human'

<http://www.psnet.ahrq.gov/resource.aspx?resourceID=1685>

Institute for Healthcare Leadership Tools

<http://www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/>

Engaging Physicians in a Shared Quality Agenda

<http://www.ihl.org/NR/rdonlyres/A30445C0-6DA6-40C0-AB12-D2592A9EF1C7/0/IHIEngagingPhysiciansWhitePaper2007.pdf>