



New Mexico
Hospital Association

Patient Safety Newsletter

Sin Daño – Without Harm

July 2007



INSIDE THIS ISSUE

NM BAND TOGETHER
for Patient Safety 1

SAFETY Culture Part 2
JUST CULTURE 1

IHI New Mexico Fully
Committed Hospital
Participation List 2

BROWN BAG TOPICS –
Working Conditions Linked
to Increase in Patient
Infections 2
Staff Meetings Critical to
learn About Patient Safety
Issues 2

TOOLS YOU CAN USE
Implement Patient Safety
Rounds Toolkit 2
PatientSafety-pedia 3

SAVE THE DATES 3
Patient Safety Resource
List 3

NEW MEXICO BANDS TOGETHER For Patient Safety –

Arizona Hospital adds a 4th color for patients “OFF-LIMB-ITS”



Several months ago, a woman (a decade post mastectomy) approached a charge nurse in Phoenix with a challenging request. She was going to be electively hospitalized soon, and wanted to avoid “having to sleep with one eye open” as she had during prior hospitalizations at various facilities. She hoped the hospital would come up with a way to make her feel safer, protected from “BP measures and lab sticks in that arm.” Rooms are dark at night so signage may not be visible and labels don't travel with the patient. In

some cases, patients who require PICC lines, dialysis access, or skin grafting/surgical repairs to extremities may not be able to communicate their needs. Or a patient may permit procedures to an affected limb because “the nurses know best.”

The hospital took this patient's concern to heart and developed a unique wristband using the term “OFF LIMB-ITS”. It was rolled out along with the three other color wristband standardization for DNR (purple), Allergy (red) and Fall Risk (yellow). The catchy term is meant to compel anyone not familiar with the wristband to ask what it means before proceeding.

The hospital selected the color bright blue for the wristband because it can be seen against any skin color or dressings and the mental association with blue and impaired circulation. Another commonly used color in other hospitals and states for the same alert message (restricted extremity) is pink because of the breast cancer association and the lymphedema post mastectomy.

This is a great example of what can happen when we engage our patients as partners in safety. They have great insight and collaboration between patient and care giver is always a win-win situation.

SAFETY CULTURE PART 2

“JUST CULTURE” IS JUST RIGHT!

The past year has seen a rise in publicized medical errors. These events have triggered questions about error prevention, the process once an error has occurred and the accountability of a medical error. This has identified a need to facilitate a deeper understanding of the Just Culture model, and will be the focus of the NMHA 2007 Annual meeting (see p. 3 for “Save the Dates”)

What is a “Just Culture?”

It's a set of standards by which everyone in an organization can work together to create the best possible outcomes,

recognizing that only through shared accountability, between the organization and the individual, between good system design and good behavioral choices of staff, will we achieve the best possible outcome.

It has also been defined as a culture in which frontline personnel are comfortable disclosing errors, including their own, while maintaining professional accountability, recognizing that individual practitioners should not be held accountable for system failings over which they have no control. Yet it does not tolerate conscious disregard of clear risks to patients or

gross misconduct (e.g. falsifying a record, performing professional duties while intoxicated). It resides within an organization's overall Safety Culture. Just Culture concepts have moved from simply a non-punitive reporting policy to a set of human resources and safety standards that dictate how the organization functions – both before and after an event has occurred.

If we've piqued your interest to learn more about Just Culture, please attend NMHA's Annual meeting Sept. 20, 2007. Leaders from the safety and risk field will facilitate sessions. Check our website for details.





Clinical Excellence Leadership Award

On May 20, New Mexico Campaign participant St. Vincent Regional Medical Center was awarded the 2007 VHA Leadership Award for Clinical Excellence for its rapid response team. This award honors organizations that have differentiated themselves around national performance standards by achieving exceptionally high levels of performance and gaining successful results

CONGRATULATIONS!



IHI UPDATE

Fifteen New Mexico Hospitals and Counting!

Your hospital can still be added to the Campaign's list of hospitals "Fully Committed" to the Campaign. You must update your hospital profile and submit mortality data via the IHI Web site. Learn more in the [Data Submission How-to Guide](#) and [Data Submission Troubleshooting Guide](#). Submitting intervention-level data is optional, but encouraged.

Here is the list of New Mexico's "fully committed" Campaign hospitals as of June 12:

Dr. Dan C. Trigg Memorial Hospital
 Española Hospital
 Gerald Champion Regional Medical Center
 Guadalupe County Hospital
 Lincoln County Medical Center
 Los Alamos Medical Center
 Lovelace Medical Center - Downtown
 Memorial Medical Center
 Miners' Colfax Medical Center
 Plains Regional Medical Center
 Presbyterian Hospital
 Presbyterian Kaseman Hospital
 Rehoboth McKinley Christian Health Care Services Socorro General Hospital
 Socorro General Hospital
 St. Vincent Regional Medical Center

STAFF MEETINGS – BROWN BAG TOPICS

ICU Nurse Working Conditions Linked To Increase In Patient Infections

Hospitals that have better working conditions for nurses are safer for elderly intensive care unit (ICU) patients, according to a recent report, led by Columbia University School of Nursing researchers that measured rates of hospital-associated infections. A review of outcome data for more than 15,000 patients, in 51 U.S. hospital ICUs, showed that those with high nurse staffing levels (the average was 17 RN hours per patient day) had a lower incidence of infections. Higher levels of overtime hours were associated with increased rates of infection and skin ulcers. On average, nurses worked overtime 5.6 percent of the time. These findings, reported in the June issue of *Medical Care*, support the notion that a systematic approach aimed at improving nurse working conditions will improve patient safety. One possible solution presented in the study suggests increasing the availability of highly-qualified float nurses through cross training. This would allow hospitals to more appropriately staff their ICUs and further develop the skills of nursing staff based on other units. (CUMC, [release](#), 5/24/07)

Staff Meetings Critical to Educate Staff on Patient Safety Issues

82% of nurses say staff meetings are critical for nurses to learn about patient safety issues. This information, according to a mention in a recent edition of *Hospitals and Health Networks*, is based on a survey of 4,750 nurses. The survey also says 94 percent of respondents agreed or strongly agreed that "sharing experiences regarding safety issues with colleagues helps prevent errors." So, take this newsletter, make copies and share it with your staff! Ask them, "What one thing concerns you or puts patients at risk, which we are not paying attention to?" The answers may be illuminating

TOOLKIT

IMPLEMENTING PATIENT SAFETY ROUNDS - PATIENT CENTERED CARE

Developed by Dana Farber Cancer Institute

Dana Farber has provided a free toolkit, based on their model of patient safety rounds. Such a program involves staff and volunteers requesting and obtaining information about actual and potential safety problems from staff and patients. The toolkit includes organizational assessments, program guidelines, training materials and other documents and tools to design and implement a similar program at other organizations. Visit our Website to download the toolkit <http://www.nmhhsa.org> Click Patient Safety Resources -> Patient Involvement.

Or you can go directly to: <http://www.dana-farber.org/pat/patient-safety/patient-safety-resources/default.html>



**New Mexico
Hospital Association**

2121 Osuna Rd NE
Albuquerque, NM
87113
PHONE:
(505)343-0010
FAX:
(505) 343-0012
E-MAIL:

einterlandi@nmhsc.com

Please contact us if you'd like to write an article 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

SEE US ON THE WEB:
<http://www.nmhhsa.org>

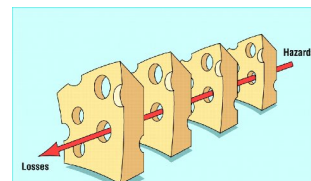
TOOLS YOU CAN USE

DO YOU NEED A PATIENTSAFETY-PEDIA?

What's the difference between an ADE and an ADR? How is Patient Safety different from Quality? What's the "blunt end" vs. the "sharp end?" Have you been afraid to ask if the "Swiss cheese model" is someone who struts down the runway with holes in her clothing?

Terms are often used as if they are interchangeable, but they are not. Communication is such an important part of our safety culture, it's important we make sure we stay well-informed. Several Patient Safety organizations

have compiled a list of commonly used abbreviations and definitions. The New Mexico Hospital Association Patient Safety Initiative has taken the most common terms and posted it on our website. Go to <http://www.nmhhsa.org> -> **Patient Safety** -> Patient Safety Terms and Definitions, and you can retrieve a copy of your very own PatientSafety-pedia:



SAVE THE DATE: The New Mexico Hospital Association Annual Meeting will be held on **September 20, 2007** at the **Albuquerque Marriott Pyramid North**. The focus will be "JUST CULTURE."

Keynote speakers on Sept. 20 will include Scott Griffith from The Just Culture Community, Dr. Michael Leonard from Kaiser Permanente, and Marti Bollman, RN from Fairview Northland Medical Center in Minnesota.

Our Patient Safety Officer (PSO) Workgroup will convene a break-out **Strategy session** 0830-0930 to review the BAND TOGETHER for Patient Safety initiative, and plan collective statewide initiatives. By working together, this workgroup can make improvements in healthcare safety at a higher level than organizations working alone.

A second break-out session 0945-1115, will combine the PSO Workgroup and the New Mexico Organization of Nurse Executives (NMONE) for a panel discussion on **Worker Fatigue & Patient Safety: Facts & Strategies**.

The cost is \$50 for the day-long meeting, including lunch. Please check our website for Registration information.

Did you notice? We have changed our name and we have a new logo!



**New Mexico
Hospital Association**

Institute for Healthcare Improvement (IHI)

<http://www.ihl.org/ihl>

National Patient Safety Foundation

<http://npsf.org>

New Mexico Medical Review Association (NMMRA)

<http://www.nmmra.org>

The Leapfrog Group

<http://www.leapfroggroup.org/>

Agency for Healthcare Research and Quality

<http://www.ahrq.gov/>

Institute for Safe Medicine Practices

<http://www.ismp.org/default.asp>

APIC-The Association for Professionals in Infection Control

<http://www.apic.org>

Joint Commission (formerly JCAHO)

<http://www.jointcommission.org/>