



New Mexico
Hospital Association

Patient Safety Newsletter

Sin Daño – Without Harm

June 2007

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IHI participating hospitals as of May 1, 2007:

Artesia General;
Dr. Dan C. Trigg Memorial;
Española;
Gerald Champion Regional;
Guadalupe County;
Heart Hospital of New Mexico
Holy Cross;
Lincoln County;
Los Alamos;
Lovelace Downtown; Lovelace
Rehabilitation; Lovelace
Westside;
Lovelace Women's;
Memorial MC;
Miners' Colfax;
Nor-Lea General;
Plains Regional; Presbyterian;
Presbyterian Kaseman; Rehoboth
McKinley Christian;
Socorro General;
St. Vincent Regional;
Union County;
University of New Mexico.

DON'T FORGET! In order to be
In order for your hospital to be
committed, you must have
submitted 12 months of mortality
data for 2006 and your profile
must be complete! Only St.
Vincent and Lincoln
County have met fully
committed criteria.

NEW MEXICO BANDS TOGETHER For Patient Safety –

Colored Wristband Standardization Toolkits on our Website and in the mail!

The New Mexico Hospital Association (NMHA) has completed the Toolkit to standardize wristband alert colors in New Mexico. This voluntary effort follows similar initiatives in many Southwestern states.



Toolkits were mailed the last week in May to all hospital CEOs, CNOs and PSOs in the form of CD-ROMs.

If you have not received yours, please call Judy Hall at 505.343.0010.

SAFETY CULTURE

WHAT IS IT? DO YOU HAVE IT IN YOUR ORGANIZATION?

"All of us in health care are participants in a hierarchical culture that has historically relied on the competence, skill, and judgment of the individual practitioner to manage quality and safety. That culture has served the medical field well—and is responsible for remarkable achievements. However, treating patients in a modern hospital setting safely, effectively, and efficiently involves a complex set of processes requiring the simultaneous, coordinated contributions of many disciplines. Traditional relationships and patterns of communication, and the command/control architecture they imply (data up, orders down), do not support the improved quality of care that healthcare professionals sincerely want to provide."

Dr. Hank Grinvalsky of the Cincinnati VA Medical Center wrote these words in 2006 when he explained the change needed to improve the culture of safety in his organization.

A Safety Culture is

defined as your observable customs, behavioral norms, as well as your unobservable assumptions, values, beliefs, and ideas shared by groups.

Attributes of a Safety Culture include:

- Leadership actively promotes and supports patient safety as a top organizational priority
- Policies foster recognition and discussion of potential and actual adverse events, causes, and ways to prevent them.
- Communications are founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.
- A systems-based approach to analyze and redesign processes of care for improving patient safety is ongoing.
- Data is collected to identify, assess, trend and measure patient safety improvements.
- An internal "safety" reporting mechanism is

available and user-friendly.

- The organization fosters employee and medical staff development and teamwork for safety-driven decision-making.
- Patients and families receive information and education as full partners in their care.
- A process exists for communicating unanticipated outcomes and adverse events to patients and families

To assess your culture of safety, you must measure it. You can diagnose, move from current to ideal and use it to identify opportunities to enhance the culture of safety in your organization.

To view the AHRQ's Hospital Survey go to:
<http://www.ahrq.gov/qual/hospculture/hospcult.pdf>,
or access it on our website www.nmhhsa.org ->Patient Safety -> Resources -> Org Culture AHRQ

STAFF MEETING – BROWN BAG TOPICS

Teaching and Testing Your Patient's Comprehension



At least 50% of U.S. adults are at increased risk for serious consequences due to low health literacy.

At least 50 percent of U.S. adults are at increased risk due to low health literacy. To further compound the situation, those at risk often hide their problem about not understanding health information due to embarrassment. This can lead to:

- Misunderstood health care instructions, prescriptions and appointment slips
- Poorer health outcomes
- Increased medical costs
- Unanticipated medical outcomes

Effective communication can bridge this gap which is important because some studies have found that nearly 70% of preventable hospital mishaps occurred because of communication problems.

When communicating to patients and their loved ones, there are steps you can take that will enhance the communication, regardless of the literacy level. One such step is to use "Teach Back", which means you ask the patient a few questions that are constructed to test what they have learned without embarrassing or intimidating them. While this is a skilled communication, it is also a very simple one to learn. It is a matter of knowing **how to ask** what they know.

The following pocket-size document has three ways to ask / test a patient's knowledge of what they have just been taught. Introduce this at a staff meeting and encourage staff to use this. This can be used with all types of education including hospital processes, such as using the call light, what their diet restrictions mean, what NPO means and why they need to comply with that, etc.

A study on patient preferences and assessment of understanding showed patients do not mind being "quizzed" about their understanding, and, in fact, prefer it to an authoritarian and/or closed-minded approach.

HELPFUL LEAD-INS TO ASSESS PATIENT OR CARE-GIVER UNDERSTANDING:

2. "We discussed a lot today. Can you tell me what you found most important?"
3. "Sometimes I give out a lot of information. Can you let me know what you heard me say? This helps me make sure I have given you the information you want and need."
4. We discussed a lot of things today. What will you tell your family and/or friends?"



OTHER HELPFUL COMMUNICATION AIDS:

- Aim for 5th–6th grade reading level on all written information. (Patients are not offended by reading clear, concise information written at levels lower than they typically read.)
- Offer to read aloud and explain.
- Underline, highlight or circle key points.
- Provide a trained interpreter, when appropriate.
- Use visual aids to help navigate the health care system and understand health information (posters, models, pictures, maps, etc.).

From **American Medical Association** "Accelerate Together" To access the entire document, go to <http://www.ama-assn.org/ama1/pub/upload/mm/370/acceleratetoolkit.pdf>

5 Million Lives Campaign's National Action Day

June 20, 2007, will mark the six-month milestone of the 5 Million Lives Campaign with the first ever **National Action Day**. This **free, day-long series of web-based sessions** (with audio) takes place from **11:00 - 5:00 PM Eastern Time**. The sessions, led by IHI faculty, Campaign scientific partners, and Campaign Mentor Hospitals, are designed to offer **practical strategies for getting lasting results faster and more reliably** on all 12 interventions in the 5 Million Lives Campaign.



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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

We're on the Web!

See us at:

<http://www.nmhhsa.org>

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



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Hospital Association

TOOLS YOU CAN USE

JOINT COMMISSION REVISED STANDARD ADDRESSES RESTRAINT AND SECLUSION

Standard PC.12.90, which addresses the requirement for in-person evaluation of a patient when restraint or seclusion is initiated, has been revised to align with the Centers for Medicare & Medicaid Services' Final Rule for Patient Rights. Issued in December 2006, the rule allows a registered nurse

or physician assistant to evaluate a patient within one hour of the initiation of restraint or seclusion, provided that such practitioner has been trained in accordance with CMS requirements and that this practitioner consults with the attending physician or a licensed independent practitioner as soon

thereafter as possible. The revised standard is effective immediately. For more information, access the Joint Commission On Line

<http://www.jointcommission.org/JointCommission/Templates/GeneralInformation>

NPSA (U.K.) TAKES ACTION ON TUBING MISCONNECTION ISSUE

The National Patient Safety Agency (NPSA) in the United Kingdom has done something that should serve as an example for regulatory authorities and manufacturers in the U.S.; they have set deadlines for NHS entities in England and Wales to adopt enteral feeding catheters that do not contain ports with female Luer connectors. Ports with female Luer connectors require the use of parenteral syringes to administer oral liquid medications.

An error was described in the ISMP Medication Safety Alert (6/15/06) in which an infant accidentally received breast milk intravenously instead of through a nasogastric tube (www.ismp.org/Newsletters)

SAVE THE DATE: The New Mexico Hospital Association Annual Meeting will be held on **September 20-21, 2007** at the **Albuquerque Marriott Pyramid North**. Keynote speakers will include Scott Griffith from Just Culture Community. Mr. Griffith, former American Airlines Managing Director of Corporate Safety, will bring a unique perspective on implementing a Just Culture in aviation

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/>