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New Mexico participating hospitals as of May 1, 2007:

Artesia General
Dr. Dan C. Trigg Memorial
Española
Gerald Champion Regional
Guadalupe County
Holy Cross
Lincoln County
Los Alamos Medical Center
Lovelace Downtown
Lovelace Rehabilitation
Lovelace Westside
Lovelace Women's
Memorial Memorial Center
Miners' Colfax Medical Ctr
Nor-Lea General
Plains Regional
Presbyterian Hospital
Presbyterian Kaseman
Rehoboth McKinley
Christian Health Care Svcs
Socorro General
St Vincent Regional
Medical Ctr
Union County
University of NM Hospital

NEW MEXICO BANDS TOGETHER For Patient Safety –

Colored Wristband Standardization Toolkits on our Website

The **New Mexico Hospital Association (NMHA)** has a Toolkit to standardize wristband alert colors in New Mexico. This follows similar efforts in several Southwestern states. **BAND TOGETHER for Patient Safety** standardizes three condition alerts:

Purple for DNR
Red for ALLERGIES
Yellow for FALL RISK



Toolkits should be available by mid-May, 2007, and will be mailed

in the form of CD-Roms to all Hospitals. If you'd like to take a look at the draft toolkit, or download the templates for sample policy, competency, staff script, quick reference card, and patient brochures, please visit our website:

<http://www.nmhhsa.org>

Patient Safety -> Resources

JOIN THE I.H.I. 5 MILLION LIVES CAMPAIGN

.....WITH THE OTHER NM HOSPITALS ALREADY PARTICIPATING – JENNIFER TROTTER, NMMRA

The 5 Million Lives Campaign is an initiative to engage U.S. hospitals in a commitment to implement changes proven to improve patient care and protect patients from five million incidents of medical harm over the next two years. To reach this goal, hospitals must begin at least one of the six new initiatives set forth by the Institute for Healthcare Improvement (IHI). The New Mexico Medical Review Association (NMMRA) and the New Mexico Hospital

Association (NMHA), serving together as your New Mexico Node, support your efforts to implement these initiatives and can help by keeping you updated on the progress of your peers in the state and across the nation.

All it takes is a commitment to work on one evidence-based change that has been proven to significantly reduce hospital mortality and morbidity. Pick at least one (you're probably already doing several of

these already (see below). Complete the Institute for Healthcare Improvement (IHI) Campaign Enrollment Form, if you did not do so for the 100,000 Lives Campaign (www.ihl.org/NR/rdoonlyres/C9C47ADD-3C7E-451A-8D62-BB58CFEFBFE4/0/HospitalEnrollmentForm5millionv03.doc). Follow the steps to include your hospital on IHI's "Fully Committed" list this June by logging in to the IHI Extranet and locating your facility's home page (www.ihl.org/extranetNG)

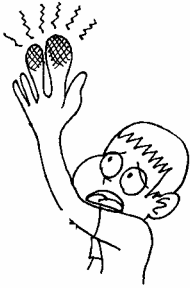
5 MILLION LIVES INITIATIVES

1. Prevent Pressure Ulcers
2. Reduce Methicillin-Resistant *Staphylococcus aureus* (MRSA) Infection,
3. Prevent Harm from High-Alert Medications
4. Reduce Surgical Complications
5. Deliver Evidence-based Care for Congestive Heart Failure
6. Get Your Boards on Board
7. Deploy Rapid Response Teams
8. Deliver Evidence-based Care for Acute Myocardial Infarctions
9. Prevent Adverse Drug Events
10. Prevent Central Line Infections
11. Prevent Surgical Site Infections
12. Prevent Ventilator-associated Pneumonia

STAFF MEETING – BROWN BAG TOPICS

May Feature #1: Prevent Patient Burns

ECRI Institute Upholds Recommendations on Warming Cabinet Temperatures Source: Risk Management Reporter, April 2007



“ Good leaders make people feel that they're at the very heart of things, not at the periphery. Everyone feels that he or she makes a difference to the success of the organization. When that happens people feel centered and that gives their work meaning.”

- Warren Bennis

Facilities should limit warming cabinet temperatures to no higher than 110°F (43°C) because heating blankets and solutions above this temperature provides no additional clinical benefit and increases the risk of patient burns, according to recommendations by ECRI Institute's Health Devices journal. ECRI Institute upheld the recommendations in an Action Item published in the 12/06 issue of Health Devices Alerts.

Problems involving insufficient heating of blankets may occur but are caused by factors other than limiting cabinet temperatures. For example, a healthcare facility may not have enough cabinet space to sufficiently warm all blankets to the desired temperatures, functional problems may prevent cabinets from reaching set temperatures, cabinet doors may be left open, or cabinets may be located too far from patient care areas, allowing warmed items to cool before reaching the patient. Staff should not compensate for these problems by raising cabinet temperatures because this practice increases the risk of patient burns.

Many facilities believe that blankets can be safely heated to higher temperatures than solutions, and they try to achieve this by designating separate cabinets for each type of item or employing cabinets that have separate compartments. In practice, however, solutions are sometimes placed in cabinets designated for blankets, even if a facility has policies to the contrary. This is dangerous because overheated solutions used for surgical irrigation have caused severe internal injuries. Also, clinicians sometimes incorrectly use solution containers as hot water bottles or as surgical positioning aids, sometimes causing skin burns. Solutions used in this manner are even more dangerous if they are overheated. To ensure safety when warming blankets or solutions, ECRI Institute recommends the following:

- Inform personnel in EDs, ICUs, post-anesthesia care units, OB units, and ORs about the dangers of setting warming cabinet temperatures above 110°F.
- Ensure that the temperature in warming cabinets cannot be set above 110°F. Consider replacing older cabinets with newer models that allow temperature limits to be set.
- Designate staff members in each clinical area to set and monitor cabinet temperatures.
- Label cabinets with intended contents (e.g., blankets, solutions). Solutions may reach dangerous temperatures if warmed in a cabinet intended for blankets.
- Inspect warming cabinets annually to ensure that they are warming contents to set temperatures. Ensure that staff unfolds blankets before using them on patients. Placing folded blankets on patients increases the risk of patient burns.
- Ensure that cabinet doors remain open for as little time as possible.
- Ensure that cabinet capacity is sufficient for blankets and volume of solution used each day.
- Locate cabinets near patient care areas.
- Consider using forced-air warmers or circulating-water hyperthermia units, if appropriate, or in-line blood/solution warmers for rapid and controlled warming of infused solutions.

For more information on Health Devices and Health Devices Alerts, send an e-mail to info@ecri.org.

May Feature #2: Open ICU visiting Hours Can Improve Patient Safety

The Institute for Healthcare Improvement (IHI) challenged hospitals a few years ago to trial “open-visiting” in Critical Care Units. Why do this? Because at the **center of every patient safety initiative** is one common theme: **the patient**. Having family there to comfort and support assists healing and promotes safety by being another set of eyes, ears and mouth.

Part of the success of open visiting is education of staff about family needs, coping strategies families may be using, and what nursing interventions may be most effective for each family's coping mechanisms

These are the elements of the trial:

1. Institute a totally unrestricted visiting policy in an ICU for families, friends, and loved ones.
2. Allow any patient who requests it to customize a personal restriction, implemented at the bedside, not through a central control system (track these requests).
3. Track “things gone wrong” attributed to open visiting as one measure of possible negative effects of the policy, conduct daily reviews of “things gone wrong” to develop mitigating plans without compromising the openness of the policy.
4. Collect positive stories and examples of favorable side effects of openness, such as innovations in enlisting visitors in the care system.
5. Improve the experience of the visitors, themselves, by asking them for ideas.

To read more about other's experience in Open ICU Visiting Hours, visit IHI's website under “Discussion Groups.”

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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 from *New Mexico Hospitals & Health Systems Association* to

**NEW MEXICO
HOSPITAL
ASSOCIATION**

Please watch for our new
Association Logo
to reflect our new name!

TOOLS YOU CAN USE

AONE WEBINAR: SAFE PATIENT HANDLING

An **AONE Webinar** on **Safe Patient Handling**

hosted by Linda L. Haney, RN, MPH, COHN-S, CSP will take place on **Thursday, May 17, 2007**.

Highlights include a review of new technologies and support practices for safe patient handling. *Diligent Corporation* is

providing a limited number of **FREE** registrations. A special bonus of one **FREE** registration to the 2008 AONE Annual Meeting in Seattle, Washington will be awarded.

Information is available at www.aone.org.

This Webinar is co-sponsored by AONE and AHA Solutions, Inc.



TOOL KIT PROMOTES SURGICAL TEAM COMMUNICATIONS FOR PATIENT SAFETY

A new online tool <<http://www.aorn.org/toolkit/patienthandoff>> by the **AORN** provides resources to help caregivers streamline and standardize communications for safe transfer of surgical patients within perioperative units. The AORN Patient Hand-Off Tool Kit, developed with the U.S. Department of Defense Patient Safety Program, helps caregivers effectively communicate key information such as the patient's current and past condition, ongoing treatments, and possible changes or complications that should be monitored closely. The kit includes sample checklists and forms, slide presentations on standardizing communication and information exchanges, and a guide to additional resources.

FREE WEBINAR FOR NURSE LEADERS

On May 16, 2007, The Nursing Leadership Congress will offer a free **Webinar** on **Mentoring Others to Create a Culture of Safety** that will focus on how to improve your organization's patient safety culture through mentoring. To register, visit: www.nursingleadershipcongress.com/webinars.asp.

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/>