Patient Safety Newsletter

Sin Daño – Without Harm **October 2007**

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WELCOME!

Oregon, Washington, and Wyoming join the WRAPS (Western Region Alliance for Patient Safety)

PATIENT SAFETY ORGANIZATIONS

The AHA, AMA, Joint Commission and other professional organizations urged Health and Human Services to promptly publish a proposed rule for Patient Safety Organizations. Authorized by the Patient Safety and Quality Improvement Act of 2005, the PSOs would confidentially collect reports of errors, near misses and perceived risks in health care, analyze those reports across health care settings, and identify potential root causes and strategies for protecting patients from potential harm. Many providers fear that patient safety event reports could be used against them in medical malpractice cases or in disciplinary proceedings. The Act addresses these fears by providing Federal legal privilege and confidentiality protections to information that is assembled and reported by providers to a PSO or developed by a PSO ("patient safety work product") for the conduct of patient safety activities. The Act also significantly limits the use of this information in criminal, civil, and administrative proceedings. It includes provisions for monetary penalties for violations of confidentiality or privilege protections. "America's hospitals, doctors and other health care professionals are committed to learning ways in which they can make the care they provide even safer tomorrow than it is today, Improving patient safety is too important to allow this regulation to be delayed further," said the groups which supported the legislation.

To read the letter, go to: http://www.aha.org/aha/letter/2007/070927-let-healthorgs-leavitt.pdf

PATIENT-FAMILY INITIATED RAPID RESPONSE TEAMS

Approximately twenty hospitals in the U.S are working to improve patient care and reduce the chance of medical errors by offering a patient/family initiated Rapid Response Teams. These programs are designed to promote family involvement in patient care and streamline communications by allowing family members to call for immediate support from the Rapid Response Team if they have seen a significant decline in the health of their loved one or if something seems not right.

"One of the salient points is that providers must trust their patients and families and suspend their disbelief about their "non-professional" status and their ability to judge the seriousness of events or changes in their cognitive and physical status," stated one of the organizers of the program. Some hospitals are reporting lower death rates and have averted medical errors since they've initiated this intervention.

To read more about one of the pioneers in Family Initiated RRTs, and download Information on the University of Pittsburgh "Condition H," visit: http://www.upmc.com/AboutUPMC/AUHome/QualityInnovation/CenterforQualityImprovementandInnovation/condition

ONE MORE ADVISORY FROM THE ISMP ON COLORED ARMBANDS……

As the organization along with the ECRI Institute who wrote the advisory from Pennsylvania on arm bands, the ISMP recommends that if hospitals and other health care facilities are using arm bands for allergies **they should not attempt** to write the name of the allergy on the armband. During hospital consultation work they have seen abbreviations (which may not be readily identifiable to all staff) used when the number of allergies exceeds the space limit, multiple bands used to identify specific allergies, names of allergies not readable due to ink smears or stains, and issues with new allergies identified during a hospitalization not being consistently written on the arm band. They believe if you use an arm band to alert caregivers of a patient's allergy it should be used as an alert to ask the patient and check the medical record - either written or electronic. Something simple like 'Allergy" or "Allergy Alert" as mentioned below is all that is required.

NECKTIES, JEWELRY BANNED FOR UK DOCTORS

The Associated Press reports that British hospitals are banning **neckties, long sleeves and jewelry** for doctors and their traditional white coats in an effort to stop the spread of deadly hospital-borne infections, according to new rules recently published. Hospital dress codes typically urge doctors to look professional, which, for male practitioners, has usually meant wearing a tie. But as concern over hospital-born infections has intensified, doctors are taking a closer look at their clothing. "Ties are rarely laundered but worn daily," the Department of Health said. "They perform no beneficial function in patient care and have been shown to be colonized by pathogens." The new regulations would mean an end to doctors' traditional long-sleeved white coats. Fake nails, jewelry and watches, which could harbor germs, are also out. The "bare below the elbows" dress code would help prevent the spread of MRSA, which accounts for more than 40 percent of in-hospital blood infections in Britain. Because the bacteria is so hard to kill, health care workers have instead focused on containing its spread through improvements to hospital hygiene. A 2004 study of doctors' neckties at a New York hospital found that nearly half of them carried at least one species of infectious microbe. In 2006, the British Medical Association urged doctors to go without the accessories, calling them "functionless clothing items." The dress code comes into force next year.

STAFF MEETINGS – BROWN BAG TOPICS

Patient Safety Challenges for Your Staff- Simple Quiz Questions part 2

Are you responsible for orientation of new staff, both professional and non-professional? Here are four new simple quiz questions you can use for staff (six original questions were highlighted in our Aug. 07 Newsletter). Answers on page 3.

1. Medication Labeling

According to experts, labels on medication containers should include which of the following?

A. Name of the medication
B. Any generic names of the medication
C. Strength of medication
D. Which patient the medication is for
E. A and C
F. A and B

2. Handoffs/handovers

Interruptions during patient handoff or handover communication should be limited as much as possible in order to ensure that:

A. Important information is not forgotten or not communicated
B. The report moves along quickly without delays.
C. Overtime is avoided

3. Universal Protocol

Preoperative verification is a process that includes verifying the correct:

A. Person
B. Procedure
C. Site
D. All of the above

4. Zeroes after decimal points

To reduce medical errors, zeros written after the decimal point are not permitted in the following:

A. Medication Orders
B. Lab Results
C. Both
D. Neither

MANY MASSACHUSETTS HOSPITALS WILL PAY FOR ERRORS

About half of Massachusetts hospitals say they have adopted policies to waive charges for serious medical errors such as wrong-site surgery and harmful medication mistakes, and others say they plan to, amid growing resistance from government and health insurers to paying for poor outcomes.

Thirty-three of 61 hospitals recently reported to **The Leapfrog Group** that they have voluntarily stopped charging for 28 serious and rare errors, called "never events." But consumer groups, health insurers, legislators, and employers are pushing for more far-reaching and mandatory policies as ways to reduce errors, and hospital executives said they expect to forgo payments in an increasing number of cases, including those in which patients require additional treatment due to hospital-acquired infections or falls.

In some cases, hospitals will not have a choice. Medicare, beginning in October 2008, will no longer pay hospitals for care resulting from eight complications, including falls, objects left inside patients during surgery, pressure ulcers, and three types of hospital-acquired infections. Medicare hopes to encourage hospitals to do more to prevent these errors. Insurers often follow Medicare's lead. In a study published last fall in the Journal Health Affairs, researchers estimated the extra cost of treating serious errors ranged from an average of $700 per case for pressure ulcers, to an average of $9,000 per case for post-surgery sepsis.

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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.

PLEASE NOTE OUR NEW WEBSITE ADDRESS
http://www.nmhanet.org

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

If you missed our Annual meeting on Just Culture, you can download the speakers' lectures and hand-outs on our website.

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

A new Web site is available to help improve the health of underserved populations. The Web site – LeadingHealthyCommunities.com – hosts a repository of best practice case studies from dozens of award-winning, community based health initiatives from around the nation. The site offers a library of information and tools that can help others successfully address issues of access, quality, cost, disparities, immunizations, prenatal care, and others. At a time of increasing problems with access to quality healthcare, this site will help organizations better succeed and meet the need of people in their communities.

The purpose of "Leading Healthy Communities" is to provide community health leaders a single source of practical information supporting the creation, financing and execution of community initiatives aimed at improving the health of the community. The site has two key components: dozens of case studies illustrating "how to be successful" and a comprehensive "action guide" that provides templates, surveys and step-by-step guides to building community support.

Downloads and links for easy access to these tools:
http://www.leadinghealthycommunities.com

THIS MONTH'S QUOTE:

PATIENT SAFETY—an aspect and goal of the healthcare system and medical care that keeps a patient free from harm

CORRECT ANSWERS – PATIENT SAFETY CHALLENGES

1. **Medication labeling**
   E: A and C; labels should include the name of the medication and the strength of the medication, according to The Joint Commission.
2. **Handoffs/handovers**
   A: Important information is not forgotten or not communicated
3. **Universal Protocol**
   D: All of the above (person, procedure, and site)
4. **Zeroes after decimal points**
   A: Medication Orders, according to the Joint Commission

Institute for Healthcare Improvement (IHI)
http://www.ihi.org/ihi
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/