



New Mexico  
Hospital Association

# Patient Safety Newsletter

Sin Daño – Without Harm

September 2007



## INSIDE THIS ISSUE

IHI FREE INFORMATION  
CALLS 1

TEN STEP ROADMAP  
FOR PATIENT SAFETY 1

BROWN BAG TOPICS 2

o Tools for Goal Setting  
with Your Patients

o New CMS Regs for Rx  
Pads

TOOLS YOU CAN USE  
The Safety Corridor  
E--library 3

Free Resources 3

SAVE THE DATES  
NMHA Annual Meeting &  
Patient Safety Officer  
Workgroup 3

## WELCOME!

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



## I.H.I. SPONSORS FREE CALLS AND INFORMATION FOR 5 M LIVES CAMPAIGN

IHI's Campaign LIVE! is your chance to learn about The 5 Million Lives Campaign and your opportunity to ask questions about anything and everything related to the Campaign. MARK YOUR CALENDAR FOR upcoming calls:

**All calls will be 2-3 PM (MT):** Sept 10, Sept 24, Oct 11, Oct 22, Nov 5, Nov. 19, Dec. 3.

Check the I.H.I. website for call-in information:

<http://www.ihl.org/IHI/Programs/Campaign/Campaign.htm>

IHI also sponsors Open Office Hours calls (at various times) on the Campaign Initiatives. Sept-Oct calls include:

Preventing Harm from High-Alert Medications (Sept. 11), Deploying Rapid Response Teams (Sept. 13), Reducing MRSA (Sept. 18), Improving CHF Care (Sept. 20), Boards on Board (Oct. 2), Preventing Pressure Ulcers (Oct.4). Check the IHI Website for call-in information and time.

## YOUR TEN-STEP ROADMAP FOR A PATIENT SAFETY JOURNEY

Like any successful journey, a successful Patient Safety Program begins with a good roadmap. If you don't know where you are and where you want to end up, it is almost certain that you will get lost somewhere along the way. A good roadmap helps you have a clear view of the journey, be prepared for the trip and reach your destination successfully. To make improvements in safety and reliability, the Greeley Company offers the following roadmap:

**Step 1: Assess where you are today:** If you don't know where you are, it is hard to make sure that the improvements that you are planning will be the correct ones.

- Evaluate your safety culture - How does your organization view safety? Is it ready for change?
- Evaluate your PI systems - Will your internal PI and quality systems support a change?
- What are the underlying common causes that lead to the majority of your issues?

**Step 2: Create your vision for tomorrow:**

A patient safety improvement program is designed to take your organization to a new place - do you clearly know where that new place is? What it looks like? Can you describe it to your staff & leadership? Are your safety goals realistic or are they accidentally driving you in the wrong direction?

**Step 3: Engage Your Leadership:**

Leadership, Physicians, Employees and Stakeholders need to be engaged. First priority is leadership engagement. What

drives them? How will you show them the benefits of a Patient Safety Program?

**Step 4: Engage Your Physicians:**

Physicians are often driven by different needs than your leadership. Physician champions are vital to getting physicians to use the error reduction tools.

**Step 5: Prevent Errors:** Every error you prevent is a good thing, but if you want your Program to be successful, you need to lay the foundation first. Once the foundation is strong, then the focus becomes developing safe behaviors and safe systems, processes and methods. This occurs by implementing strong behavioral expectations, good error reduction tools, pro-active process evaluation and improvement, and effective FMEAs.

**Step 6: React to Errors:** Even if we prevent a majority of our significant errors, in reality, we will always need to be able to quickly respond to significant errors and implement corrections and improvements in a timely fashion.

- Does your Cause Analysis process get to the real underlying cause?
- Is your occurrence report data an early warning system? Do you see problems coming or do they keep surprising you?

**Step 7: Focus & Execute:**

This can be a stumbling block on the road to success. Improvements get defined but just don't seem to get done. Areas to focus on here are accountability and prioritization. Other high risk

industries and the manufacturing sector have developed some excellent tools to help make sure actions get appropriately prioritized and completed on time.

**Step 8: Transition from external drivers to internal drivers:**

Most organizations are still highly driven by external requirements (Joint Commission, state regulators, etc.) But at some point, for a truly successful and sustainable program, the drivers must come from within. If we implement the first seven steps, compliance with the external requirements becomes an outcome of our own process, not the driver.

**Step 9: Capture the ROI:**

Patient and Employee Safety is the right thing to do, it is the moral thing to do, and it is also "good business". Every safety error weakens your business effectiveness and is reflected, ultimately, in the organizations reputation, market share, and financial performance. Improved safety can have a significant return on investment and positive impact on the bottom line - but you have to be able to show that to leadership and employees.

**Step 10: Build Sustainability:**

There will never be a time where we can go back to a period of "less safety". Sustaining a program in the long haul is a real challenge. Start planning now to make your Patient Safety Program a continuous process.

Written by Bob Murder, M.D  
Practice Director, The Greeley  
Company  
(<http://greeley.com>)

**STAFF MEETINGS – BROWN BAG TOPICS****Tools for Goal Setting With Your Patients**
**AHRQ Seeks  
Submissions for New  
Health Care Innovations  
Exchange Web Site**

AHRQ is seeking submissions for its new Health Care Innovations Exchange, an initiative that is designed to support you in sharing and adopting innovations that improve health care quality. The two components are a searchable, Web-based national repository of health service innovations and dynamic communities of learning. Through the Web site, physicians, nurses, and other health professionals and providers will be able to obtain detailed profiles of innovative activities and tools, and have opportunities to exchange successes, failures, stories and lessons learned with innovators and fellow adopters. Users of this site will also have access to educational materials on how to innovate.

Innovations described will represent varying degrees of novelty and scientific rigor and cover many clinical disciplines and care settings in both the public and private sector. The dynamic communities of learning will allow for collaboration and cross-disciplinary interactions that will heighten understanding of the relevance of an innovation to a potential adopter's organizational contexts and expand on the effort needed to replicate uptake of the innovation. The goal is to accelerate change and transformation in real-world health care. To learn more about how to submit innovations or get added to the listserv, visit the AHRQ Web site at [www.innovations.ahrq.gov](http://www.innovations.ahrq.gov).

For more information about the AHRQ Health Care Innovations Exchange, please contact Cheryl Thompson at (301) 427-1271 or via email at [cheryl.thompson@ahrq.hhs.gov](mailto:cheryl.thompson@ahrq.hhs.gov).

We often assume that the patient has been included in their goal planning. From the patient's perspective, this should happen more often.

A woman called a local hospital. "Hello, could you connect me to the person who gives information about patients? I'd like to find out if a patient is getting better, doing as expected or getting worse." The voice on the other end said, "What is the patient's name and room number?" "Sarah Finkel, Room 302."

"I'll connect you to the nursing station".

"Third floor nursing station. How can I help you?"

"I'd like to know the condition of Sarah Finkel in Room 302."

"Just a moment. Let me look at her records. Mrs. Finkel is doing very well. In fact she had two full meals and her blood pressure is fine. She will be taken off the heart monitor in a couple of hours, and if she continues this improvement, Dr Cohen is going to send her home on Tuesday."

The woman said "What a relief. That's wonderful news!"

The nurse said, "From your enthusiasm, I take it you are a close family member, or a close friend?"

"Neither. I'm Sarah Finkel in Room 302. Nobody tells me squat!"

This scenario may be a bit over the top, but your patients want to be involved in their goal setting. They want information about their discharge and medication, when they can go home, and how much pain they're should have. So much of our work as caregivers takes us away from the patient's bedside. This intervention can help bring us closer to patients and their families.

Here are some tools used as tent cards (developed by the University of California-San Francisco) to make it easier to involve patients in their care by working with them to set their goals while hospitalized.

**Tell Us!****Please tell us Your Goal for Today**

You are the most important part of your healthcare team. With your help we can provide you with the safest care possible.

Tell Us a goal that will improve your care.

EXAMPLES OF YOUR GOAL MIGHT BE:

- ♦ TO TALK WITH YOUR DOCTOR
- ♦ TO FIND OUT THE RESULT OF A TEST
- ♦ TO DISCUSS A MEDICATION
- ♦ TO TALK ABOUT AN UNEXPECTED SYMPTOM

**WE WILL POST YOUR DAILY GOAL ON YOUR WHITEBOARD**

DAY/DATE: \_\_\_\_\_ ROOM/BED: \_\_\_\_\_

TODAY'S GOAL: \_\_\_\_\_

TELL US ANY CONCERNS YOU HAVE ABOUT YOUR WELL-BEING OR SAFETY. YOU MAY ALSO USE THE SPACE INSIDE THIS CARD TO WRITE ANY NOTES OR COMMENTS FOR MEMBERS OF YOUR HEALTHCARE TEAM

**PLEASE GIVE THIS CARD TO YOUR NURSE.****An Important Reminder about Your Discharge:**

WHEN YOU LEAVE THE HOSPITAL, YOU WILL BE GIVEN AN UPDATED LIST OF YOUR MEDICATIONS. IT WILL TELL YOU HOW AND WHEN TO TAKE THEM. BE SURE TO FOLLOW THE INSTRUCTIONS.

**NEW CMS REGULATION FOR PRESCRIPTION PADS**

Effective Oct. 1, 2007 CMS will require a tamper resistant prescription pad that must contain at least one of the following characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.



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

[einterlandi@nmhsc.com](mailto: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.

**PLEASE NOTE OUR NEW WEBSITE ADDRESS TO GO ALONG WITH OUR NEW NAME:**  
<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

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

### Patient Safety and Quality Healthcare Offers Complimentary Subscription

The publisher of *Patient Safety & Quality Healthcare* magazine is offering two opportunities to stay up-to-date on the latest news. You may subscribe to the complimentary bi-monthly magazine written for and by people directly involved in improving patient safety and quality of care by going to [www.psqh.com](http://www.psqh.com), click on subscriptions and enter 0707PGS in the keycode field. Your subscription will begin with the next issue.

There is also an e-newsletter that offers healthcare professionals a timely method every month with news headlines and links to products and company information impacting the business of patient safety and quality care. To subscribe to the e-newsletter, simply click on [www.psqh.com](http://www.psqh.com), and enter code 0707PGE.

### Pediatric Resources Available

If you need help adapting your patient safety initiatives to your pediatric population, the I.H.I. 5 Million Lives Campaign has a pediatric node. Each webcast will feature practices successfully implemented by hospitals across the country. The next session, focusing on Rapid Response Teams, is on September 26, 2007. **Each call is free, but registration is required** at

[http://www.surveymk.com/s.aspx?sm=zaCxoJ132TYeUuax3uGr0g\\_3d\\_3d](http://www.surveymk.com/s.aspx?sm=zaCxoJ132TYeUuax3uGr0g_3d_3d).

For the list of upcoming calls, go to <http://www.nichq.org/NR/rdonlyres/ED8211AD-AA41-4788-897E-8CB54828B7E2/0/2007PediatricWebcastSeriesInfoFlyer062007.pdf>.

**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**."

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 New Mexico Organization of Nurse Executives (NMONE) and anyone interested in patient safety for a panel discussion on **Worker Fatigue & Patient Safety: Facts & Strategies**.

The cost is \$50 for the day-long meeting, including lunch. 3.0 CEUs are available for nurses attending the Keynote sessions. Please check our website for Registration information.

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/>