



New Mexico
Hospital Association

Sin Daño – Without Harm

♥ February 2008 ♥

Patient Safety Newsletter

IHI SPONSORS PRESSURE ULCER EVENT IN NEW MEXICO

New Mexico targets zero pressure ulcers by working across health care settings.

On, January 17, over 150 people gathered to learn more about pressure ulcer prevention. The event brought together 50 New Mexico hospitals, nursing homes, and home health agencies. Upon arriving, each participant was given a nametag with a colored sticker on it. Later, it was revealed that the color of the stickers corresponded to the participant's region of the state. Based on this information, attendees were

instructed to have lunch with their neighbors from different facilities and to talk about how they could join forces to prevent pressure ulcers.

IHI faculty expert Kathy Duncan shared pressure ulcer prevention strategies along with "tips and tricks" she has picked up from visiting hospitals throughout the US. Karen Clay, president of Kare N' Consulting, declared that she and Kathy must have been twins separated at birth (because they echoed so many of each other's comments) and

also spoke on pressure ulcer prevention and wound care. The event was sponsored by the **New Mexico Medical Review Association** (NMMRA), and the **New Mexico Hospital Association**. The **New Mexico Health Care Association** has also committed to a joint effort to reduce the incidence of pressure ulcers statewide.

The commitment among hospitals, nursing homes, and home health agencies to work across health care settings was truly inspiring!

CREATING A CULTURE OF DATA ACCEPTANCE AND EXTERNAL ACCOUNTABILITY

From Oct. 2007 Patient Safety Quality Monthly-The Greeley Company – Dr. Bob Marder.

The two common and related themes affecting healthcare culture today are **accountability** and **transparency** in regard to quality and patient safety. Government, regulators, employers, and consumers are all demanding greater accountability of healthcare organizations and individual providers through greater transparency of information. This is a difficult transition for most of us because we have had a long tradition of a lack of questioning of what we do and how we do it. This culture of autonomy pervades our professional views as caregivers and leaders. It is not surprising that this loss of autonomy is causing real anguish. There is no sign that this loss of autonomy is a passing fad. The movement to provide publicly available data about clinical practices and outcomes through Joint Commission, CMS, and state initiatives is growing. In addition, external data are driving reimbursement through pay-for-performance

programs. And the reason this movement will not retreat is because external accountability through publicly available data has worked to change practices.

So what should we do? The answer is we need a culture that can adapt to this new order. There are three types of cultures related to external data:

1. **Resistant**
2. **Tolerant**
3. **Embracing**

The organizations that will survive will be the ones that adopt the third approach - embracing. Those organizations will say, "Bring it on! Give us all the data you have as soon as we can have it." They will seek to be ahead of the curve.

How can you create such a culture? Apply the four stages of loss to this question: denial, anger, depression, and acceptance. There is a real loss of autonomy through external data that shows something about us that we may not want to know and share with

the rest of the world. Just like the loss of a loved one must be addressed before a person can move on with his or her life, this loss of autonomy must be acknowledged and managed. Next, leaders - both hospital administrators and physicians - must strive to create a new culture of acceptance of external accountability.

Here are three actions that can make a difference in a patient satisfaction culture:

1. **Set behavioral expectations for external data use** - no "pity parties" about data validity or burden - no dismissal of the data because of reputation - no superficial excuses about performance-only analysis and action.
2. **Keep everyone informed**, even if the results are poor. Distribute data widely and publicly.
3. **Set clear targets for excellence**, not just acceptable performance. Celebrate and reward improvement but don't lose focus on the goal.

PROTECTING
5 Million lives
FROM HARM
SOME IS NOT A NUMBER. SOON IS NOT A TIME.

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Free Resources

MARCH 2-8, 2008
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PATIENT SAFETY AWARENESS WEEK

[HTTP://NPSF.ORG/HP/PSAW](http://NPSF.ORG/HP/PSAW)

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ZERO – TOLERANCE For Catheter-Related Bloodstream Infections

The Healthcare Infection Control Practices Advisory Committee of the CDC recommends that hospitals implement comprehensive educational programs to teach proper CVC insertion and maintenance techniques. Those include:

- Use of maximal barrier precautions (i.e., surgical mask, sterile gown, sterile gloves, and sterile drapes);
- Catheter placement in the subclavian vein rather than an interior jugular or femoral vein;
- Changing catheters only when necessary;
- Changing CVC exit-site dressings only when soiled, bloodied, or become non-occlusive.

Other standards that should be adhered to include:

- Aseptic technique should be used for changes to all add-on devices such as stopcocks, extension sets, injection and access caps, and needleless systems.
- To prevent the entry of a microorganism into the vascular system, the injection or access port shall be aseptically cleansed immediately prior to use.
- Anytime an injection or access cap is removed, it should be discarded, and a new sterile one should be attached (Infusion Nurses Society, 2006). (A complete listing of the 2006 Infusion Nursing Standards of Practice is available on the INS web site at www.ins1.org.)

To access the full article go to: <http://www.psqh.com/novdec07/zerotolerance.html>

STAFF MEETINGS – BROWN BAG TOPICS

Quiz on Hand-Offs, Universal Protocol and Patient Safety Goals

Answers on p. 3

1. What are two goals of a handoff policy?

- A. To facilitate a two-way exchange of information and to limit distractions and interruptions
- B. To inform patients of their rights and to limit the number of falls in the facility
- C. To provide verbal, face-to-face communication and to provide handoffs in the same manner each time
- D. To ensure that nurses keep a patient's treatment plan secret and to help staff plan for a patient's discharge
- E. A and C
- F. B and D

2. Universal Protocol: Where should the final surgical site verification occur?

- A. In the pre-operative area, right before going to the operating room
- B. On the nursing unit, before the patient comes down to the operating room
- C. At the location where the procedure is to be performed

International Patient Safety Goal Word Jumble

Word games like this one can help staff become familiar with terms and phrases often used in discussions about patient safety. Below are some mixed-up phrases associated with the Joint Commission International's IPSGs. Can you unscramble?

- A. etanpit iteatnofcinid _____
- B. brelav esorrd _____
- C. arda kbac _____
- D. tcairilc stte slrsuet _____
- E. dleneisc ivgrceera _____
- F. tamiuomoniccn _____
- G. udrg oanettironcnc _____
- H. lkoo-kelia ugsdr _____
- I. nduos-leaki dusrg _____
- J. iagnmrk glurcasi itse _____
- K. emit-tou _____
- L. rudepvpano bvibtaeoiran _____
- M. ahnd ngwhsia _____
- N. ailincccl ralam msytes _____



“PEARLS” OF PATIENT SAFETY

This month's “pearl” is “SHOW ME THE MARK.”

A hospital in Oregon suggests a creative idea for double-checking surgical or procedure sites. They have added a quick initial step for healthcare professionals working with patients having surgery or a procedure. Prior to any

intervention in the surgical suite, such as prepping the area, the healthcare professional would request “show me the mark,” to verify the surgical site. Two healthcare professionals then agree to the accuracy of the marked site before proceeding with, for example, a local block.

This quick double-check complements the “time-out,” and adds an additional safeguard without slowing down the normal O.R. flow.



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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.

OUR WEBSITE ADDRESS:

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

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

IMPLEMENTING A PROGRAM OF PATIENT SAFETY IN SMALL RURAL HOSPITALS TOOLKIT AVAILABLE

A safe, informed culture must be engineered by understanding its four components and then deliberately implementing the practices that support these components. This University of Nebraska website provides tools to *engage* the audience about the importance of the change, to *educate* the audience about what they need to do, to ensure the audience can *execute* the change, and to *evaluate* whether the change made a difference.

<http://www.unmc.edu/rural/patient-safety/overview/overview.htm>

FREE E-NEWSLETTER

Patient Safety and Quality Healthcare now offers a way of staying up-to-date with most important information and product news relating to the entire arena of patient safety and quality healthcare issues. You can receive the **PSQH e-Newsletter** for free by accessing:

<http://www.psqh.com/forms/psqhnews.shtml>

INFORMED CONSENT – EVERYONE'S FAVORITE TOPIC

While CMS' new, less prescriptive Informed Consent Interpretive Guidelines were hailed as good news throughout health care, they still pose a challenge to health care organizations by expanding the scope of what may be reviewed during a state or CMS audit. To read more about CMS Compliance and Patient Safety with Automated Informed Consent go to:

http://www.hhnmostwired.cm/hhnmostwired_app/jsp/articledisplay.jsp?dcrpath=HHNMOSTWIRED/Article/Fall2007/071219MW_Online_Rozovsky&domain=HHNMOSTWIRED

WHEN SENIOR LEADERS “GET IT”

Do you know when your senior leaders finally get it? An article about how to recognize when your senior leadership team is on the right track can be found at:

<http://www.ihconline.org/toolkits/CultureOfSafety/WhenSeniorLeadersGetIt.pdf>

DOOR-TO-DOC PATIENT SAFETY TOOLKIT Phoenix, AZ, Banner Health

This AHRQ-funded toolkit provides templates to help hospitals implement an initiative to improve patient flow processes by reducing the time emergency department patients wait to be seen and admitted. The model is also designed to gain front-line practitioner acceptance of these changes and to improve both efficiency and patient safety.

IMPLEMENTING A PHARMACY WASTE MANAGEMENT SYSTEM

Premier hosted a public webcast to understand the problem of pharmaceutical waste and suggest solutions and tips on how to separate, label and dispose of common chemicals and drugs. The webcast describes how hospitals can bring their organizations into compliance with current EPA hazardous waste regulations and Joint Commission requirements while preparing for future disposal restrictions. To access the materials go to:

http://www.premierinc.com/quality-safety/tools-services/safety/news/2007/11/PharmaSafetyStory_11162007.jsp

Answers to quiz, p.2

1. **E.** Both A and C are correct, according to expert sources.
2. **C.** At the location where the procedure is to be performed, according to Universal Protocol standards.

WORD JUMBLE: patient identification, verbal orders, read back, critical test results, licensed caregiver, communication, drug concentration, look-alike drugs, sound-alike drugs, marking surgical site, time-out, unapproved abbreviation, hand washing, clinical alarm system