



New Mexico
Hospital Association



Patient Safety Newsletter

Sin Daño – Without Harm

AUGUST 2010

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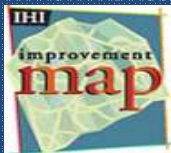
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PSO Update from AHRQ

NMHA and NMMRA are the co-nodes for the Institute for Healthcare Improvement (IHI) in New Mexico



NMHA is proud to support the New Mexico CLABSI Collaborative



Healthcare Associated Infections Program

The NM Healthcare Associated Infections Program (HAI) was developed as a result of the mandate in NM Statute §24-29-1 (2009).

This Act addresses implementation of surveillance to prevent HAIs. The Act provides initial statutory framework to implement the program. It gives the NM Department of Health and the Advisory Committee specific authority to conduct certain functions:

- Recruit hospitals to participate voluntarily, and, mandate reporting by hospitals the Advisory Committee deems “qualified” by July 2011;
- Determine reportable measures/indicators;
- Develop the HAI surveillance program;
- Develop and disseminate public reports.

For the upcoming legislative

session, there are several issues that NMHA and the Advisory Committee plan to address for clarification of the law:

- Future mandatory vs. voluntary reporting (all hospitals “shall” report...)
- Rule promulgation authority
- Protective provisions (confidentiality)
- Clarity of facility identifiers in public reporting
- Protection for submitted data, for discoverability
- Standard of care statement
- Applicable to hospitals only

The HAI Advisory Committee has recommended that the following indicators be added:

1. non-ICU CLABSI reporting, and
2. *clostridium difficile* infection reporting.

Currently, twelve NM hospitals are reporting into the National Healthcare Safety Network (NHSN). Support for hospitals and healthcare organizations includes the CLABSI Learning Collaborative (through April 2011), and a proposed CDI Learning Collaborative to begin April 2011. This education will be crucial for upcoming regulatory requirements for Medicare participating hospitals. The current proposal is that hospitals will collect data (most likely through NHSN) on two HAIs which would influence Medicare payment determinations starting in fiscal year 2013.

Joint Commission’s NPSG 7: “Reduce the risk of healthcare associated infections” contains requirements for hospital and critical-

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AHRQ Updates State Snapshots

The Agency for Healthcare Research and Quality has updated its State Snapshots with data from 2009. The State Snapshots break down healthcare quality information by state to help both the public and private sectors understand disparities among states. The latest update includes new data on health. The State Snapshots provide State-specific health care quality information, including strengths, weaknesses, and opportunities for improvement. The goal is to help State officials and their public- and private-sector partners better understand health care quality and dis-

parities in their State. State-level information used to create the State Snapshots is based on data collected for the *National Healthcare Quality Report*.

State Selection Map

The State Selection Map allows you to choose your State to explore the quality of your State’s health care against national rates or best performing States.

Performance Measures

The summary measures quality of care and States’ performances relative to all States and the region by:

- Overall health care quality
- Types of care (preventive, acute, and chronic)

- Settings of care (hospitals, ambulatory care, nursing home, and home health)
- Five clinical conditions (cancer, diabetes, heart disease, maternal and child health, and respiratory diseases)
- Special focus areas on diabetes, asthma, Healthy People 2010, clinical preventive services, disparities, payer, and variation over time.

<http://statesnapshots.ahrq.gov/snaps09/map.jsp?menuId=2&state=>



Healthcare 411

NEWS SERIES FROM AHRQ

Healthcare 411 is a free bilingual online resource that educates and empowers consumers with evidence-based information. Produced by the Agency for Healthcare Research and Quality (AHRQ), these weekly audio programs feature consumer-friendly health news and information. Subscribers to *Healthcare 411* will receive relevant and timely information enabling consumers to take an active role in their health care. The series is designed to help provide people with the latest research findings, news and consumer health care information to ensure patient safety. The English series is released weekly and the Spanish is released bi-weekly.

Take a tour of the Healthcare 411 web site by visiting: www.healthcare411.ahrq.gov. Click on the program or feature presentation of your choice to either hear them on your computer or to download them to a portable digital player such as an iPod. Users also can subscribe to the series and receive the latest features via podcast technology. Healthcare 411 audio programs are produced in a variety of formats. All content on the web site can be accessed by key word and by date range. In addition, transcripts are available for all programs and public service announcements. This gives consumers and health care professionals a variety of ways to access information quickly and efficiently. Program and feature presentations vary in length from two to ten minutes. All new, as well as archived, programs remain available on the Healthcare 411 web site.

Dealing with Patient Alarm Fatigue

In an article from NurseZone.com®, the author describes a patient death at a prestigious hospital that was attributed to a phenomenon known as alarm fatigue. The patient's cardiac arrest monitor had been in alarm mode for over 20 minutes before the patient died. Alarm incidents were ranked in the top 10 technology-related health hazards for 2010 by the ECRI Institute.



http://www.nursezone.com/Nursing-News-Events/more-news/No-False-Alarm-Dealing-with-Patient-Alarm-Fatigue_34584.aspx

Staff Meetings BROWN BAG TOPICS

Are Artificial Nails Banned by OSHA?

In a recent blog on artificial nails for healthcare workers, it was reiterated that OSHA doesn't ban artificial nails, but the Centers for Disease Control and Prevention (CDC) has guidelines that mention patient safety and artificial nails:

- Do not wear artificial fingernails or extenders when having direct contact with patients at high risk (e.g., those in intensive-care units or operating rooms).
- Keep natural nails tips less than 1/4-inch long.



The reference can be found in Section 6 at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm>

To read the full blog on HCPro, go to:

http://blogs.hcpro.com/osha/2010/07/ask-the-expert-artificial-nails-for-healthcare-workers/?utm_source=ohc&utm_medium=eNL&utm_campaign=20100713

New Way Bacterium Spreads in Hospital

In a recent article in the New York Times, health care workers and patients have yet another source of hospital-acquired infection to worry about. According to British researchers, *Clostridium difficile* (CDI), a germ that causes deadly intestinal infections in hospital patients, has long been thought to be spread only by contact with contaminated surfaces. But a new study finds that it can also travel through the air. The researchers emphasized that there is no evidence that CDI can be contracted by inhaling the germs. Rather, they float on the air, landing in places where more people can touch them. To read the full article, go to:

http://www.nytimes.com/2010/05/25/health/25infect.html?_r=1&ref=health

CMS 30 Minute Rule for Medication Administration Update

The Institute for Safe Medication Practices has suggested that "CMS 30-minute rule may result in unintended consequences" in the July edition of the *ISMP Medication Safety Alert! Nurse Advise-ERR*. They are concerned about work-arounds and practices that may be used to meet the requirement but that may place patients at risk. ISMP will be having discussions with CMS but are first soliciting nursing feedback with a survey available through August 31 on Survey Monkey

www.surveymonkey.com/s/30mr. To read the article, go to: <http://ismp.org/newsletters/default.asp>

Results! Why, man, I have gotten a lot of results. I know several thousand things that won't work."

- Edison, Thomas A



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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.

For a list of Patient Safety Best Practices previously highlighted in our Newsletter, please go to: <http://www.nmhanet.org/quality/patient-safety/the-patient-safety-corridor-e-library/general-patient-safe-ty/Compendium%20of%20NM%20Patient%20Safety%20Best%20Practice.pdf>

OUR WEBSITE ADDRESS:

<http://www.nmhanet.org>

About Our Organization...

NMHA is the non-profit trade organization representing 42 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 RADAR SCREEN FREE RESOURCES



Time Frame for Spiking IV Bags?

A Q&A on CMS compliance, common pitfalls, and best practices addresses this topic. This document references US Pharmacopeia (USP 2008), A General Chapter <797> Pharmaceutical Compounding – Sterile Preparations, which addresses time limits for spiking IV bags. http://blogs.hcpro.com/osha/2010/06/time-frame-for-spiking-iv-bags/?utm_source=icwm&utm_medium=eNL&utm_campaign=20100630

Joint Commission Urges Americans to 'Speak Up' to Prevent Falls

Each year, millions of people—from elderly nursing home residents to hospitalized children to women who have just given birth—are injured by falls in health care facilities and homes. The Joint Commission has launched a national campaign to help Americans reduce the risk of falling.

The new education campaign, which is part of The Joint Commission's award-winning **Speak Up**™ program, recognizes that falls are a serious problem. Statistics from the Centers for Disease Control and Prevention (CDC) show that falls are the second leading cause of injury-related deaths for people ages 65 and older, and are the most common cause of injuries and hospital admissions among the elderly. (Source: CDC, NCHS. Mortality Data Tapes. Hyattsville, MD: the Center, 1998.)

http://www.jointcommission.org/NewsRoom/NewsReleases/nr_speakup_falls.htm

Take a Deep Breath: New CMS Anesthesia Regulations

Though Centers for Medicare and Medicaid Services (CMS) expectations for Anesthesia Services have changed little over the years, these Conditions of Participation (CoPs) were recently revised and published in Transmittal 59 dated May 21, 2010. This four-part series from Compass Clinical Consulting outlines compliance challenges associated with the new CMS CoPs for Anesthesia Services, and offers solutions to help hospitals assess vulnerabilities in anesthesia and sedation activities.

- Part I: Defining Anesthesia Services
<http://www.compass-clinical.com/part-1/>
- Part II: Anesthesia Administration and Privileging Practitioners
<http://www.compass-clinical.com/part-2/>
- Part III: Responsibilities of the Anesthesia Services Department
<http://www.compass-clinical.com/part-3/>
- Part IV: Pre- and Post-anesthesia Evaluation
<http://www.compass-clinical.com/part-4/>



New FAQs on Multi-Dose Vials

The Joint Commission Web site now includes new Frequently Asked Questions about multi-dose vials. Questions about the standards and FAQs can be submitted to the Standards Interpretation Group. To read more, go to:

http://www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/MM/Multi-dose_Vials.htm

ISMP Offers Guidelines for Standard Order Sets

<http://www.ismp.org/Tools/guidelines/StandardOrderSets.pdf>

Joint Commission Announces Revised NPSGs That Relate to Clinical Practice

<http://www.jointcommission.org/NR/rdonlyres/EE4702F5-569E-4A3D-9925-7EE265ECA982/0/jconlineJune2310.pdf>

Information on Patient Safety Organizations from AHRQ



The Agency for Healthcare Research and Quality (AHRQ) has provided this information on Patient Safety Organizations, the Network of Patient Safety Databases, and the Patient Safety and Medical Liability Initiative. Additional information may be obtained through the reference links.

Patient Safety Organizations

The Patient Safety and Quality Improvement Act 2005 (the Patient Safety Act) authorized the creation of PSOs and encourages clinicians and health care organizations to voluntarily report and share quality and patient safety information without fear of legal discovery. To implement the PSA, the Department of Health and Human Services issued the Patient Safety and Quality Improvement Final Rule (Patient Safety Rule), effective January 19, 2009. The Patient Safety Rule establishes a framework by which hospitals, doctors, and other health care providers may voluntarily report information to PSOs, on a privileged and confidential basis, for the aggregation and analysis of patient safety events. In little more than a year since the program began, there have been over 85 PSOs listed by AHRQ. Additional information on PSOs can be found at AHRQ's website at

<http://www.pso.ahrq.gov/psos/fastfacts.htm>

Network of Patient Safety Databases

The Patient Safety Act authorizes AHRQ to facilitate the development of a Network of Patient Safety Databases (NPSD), to which PSOs, health care providers, or others can voluntarily contribute nonidentifiable patient safety event information. The goal of the NPSD is to facilitate aggregation and analyses of patient safety event information to help reduce adverse events and improve health care quality. The NPSD is currently under development. It is anticipated that the NPSD will be ready to receive non-identifiable information in late 2010. To allow aggregation of comparable data, the NPSD will employ common definitions and reporting formats for patient safety events. These interoperable terms are referred to as the Common Formats. To provide PSOs with resources to de-identify patient safety event information prior to sending the information to the NPSD, AHRQ established the PSO Privacy Protection Center (PSO PPC).

Patient Safety and Medical Liability Projects

On September 9, 2009, President Obama addressed a joint session

of Congress to announce his proposals for health insurance reform. One component of such a plan includes investing in new ways to manage medical liability claims. In order to implement the Patient Safety and Medical Liability Initiative, on June 11, 2010, AHRQ announced the funding of 20 patient safety and medical liability projects (patient safety projects) to allow states and health care systems to develop, implement, and evaluate evidence-based patient safety and medical liability models. The projects are intended to (1) put patient safety first and work to reduce preventable injuries; (2) foster better communication between doctors and their patients; (3) ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reduce liability premiums. Some of the patient safety projects investigate disclosure and compensation, identify best practices for using disclosure to improve patient safety, and disseminate best practices with a focus on incorporating patient and family input into efforts to understand why errors occur. Additional information on these projects can be obtained at AHRQ website at

<http://www.ahrq.gov/qual/liability/#moreinfo>

Healthcare Associated Infections Program (Continued from p. 1)

access hospitals. These requirements are related to preventing HAIs due to multidrug-resistant organisms (MDROs), central line-associated bloodstream infections (CLABSIs), and surgical site infections (SSIs). Visit the website for updates:

http://www.jointcommission.org/NR/rdonlyres/868C9E07-037F-433D-8858-0D5FAA4322F2/0/July2010NPSGs_Scoring_HAP2.pdf

The new Joint Commission requirements related to CLABSIs also apply to ambulatory care facilities and office-based surgery

practices, home care organizations, and long-term care organizations. In addition, prevention of SSIs is a new requirement for ambulatory care facilities and office-based surgery practices.

"I want doctors and nurses to slow down, look at the patient, communicate with each other, doctors to nurses, one team to another."

Sorrel King, Founder of the Josie King Foundation, and a leading lay patient safety advocate