



New Mexico
Hospital Association



Patient Safety Newsletter

Sin Daño – Without Harm

March 2010

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



THE NEW MEXICO CLABSI COLLABORATIVE

In 2009, under the guidance of the state's Healthcare Associated Infections Advisory Committee (HAI AC), a group of six hospitals in New Mexico began the process of submitting data on central line-associated bloodstream infections (CLABSI) in intensive care units to the NM Department of Health using the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). In 2010 more New Mexico hospitals will voluntarily begin submitting data on these infections, and eventually this information will be publicly reported in an effort to help consumers make better choices for health care. While collecting and reporting data for surveillance is an important step, the ultimate goal is to prevent the incidence of these infections by improving processes of care for patients with central line catheters. Hospitals can benefit from a Collaborative that is focused on learning and adopting the best local and national im-

provement methods for our state.

This Collaborative is an opportunity for NM hospitals to learn and adopt the best methods for prevention. Collaborative participants will enjoy the guidance of local and national experts who will share their experience in implementing improvements for CLABSI prevention.

This is the first HAI prevention Collaborative to be funded by the NM Department of Health through the American Recovery and Reinvestment Act (ARRA) grant. It supports the overall State plan for surveillance, reporting, response, education and communication for health care associated infections.

The program is voluntary and open to all hospitals in the state that are interested in learning more about how to prevent these infections. It is a team-based design, requiring the leadership of each hospital to create and support a dedicated project team of clinicians and others most involved in the placement and management of central line catheters.

There is no cost for participation in the Collaborative. Hospital leadership will need to commit the time and resources to the team to attend four learning sessions and brief monthly teleconferences, along with implementing improvements and collecting data during the project. Funding is available to assist with some travel-related expenses of attendance. The Collaborative will begin in April 2010 with a full day session April 30, and subsequent sessions in August, December, and April 2011.

An informational Webinar will be held on:

**-Friday, March 26, 2010
1:15pm to 2:30pm**

For more information on the CLABSI collaborative and the March Webinars, contact Anne Timmins at the New Mexico Medical Review Association (NMMRA) at 505.998.9754.

MECHANICAL VENTILATORS IN U.S. ACUTE CARE HOSPITALS

As part of the response to 2009 H1N1 flu this year, the U.S. Department of Health and Human Services Office of Preparedness and Emergency Operations partnered with the American Association for Respiratory Care (AARC) to conduct a comprehen-

sive inventory of the total number and types of mechanical ventilators in every U.S. hospital.

The inventory results indicate that there are enough mechanical ventilators in the U.S. to meet nationwide demand **IF** severity of the pandemic remains similar to the current U.S. experience.

To read the full article, go to: <http://www.hhs.gov/disasters/discussion/planners/mechanicalvent.html>

To see how New Mexico and our immediate neighbors fared in the Inventory, turn to page 4.

"The difference between getting somewhere and nowhere is the courage to make an early start. The fellow who sits still and does just what he is told will never be told to do big things."

--Charles Schwab,
Entrepreneur

Staff Meetings

BROWN BAG TOPICS – PATIENT SAFETY WORD SCRAMBLE

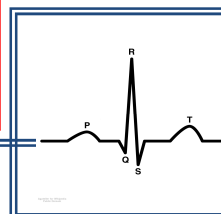
Can you find and circle words, which are all related to patient safety?

G N S H H M V D N S E D J U V
Y D O D A D I O I X D N G I W
D B J I R N I T J W I P D Q A
Y V D I T T D U C Z E E Q W N
D O B U C A A O J L N I P I O
N W Y E H O C I F T B V A Q I
J P F L I U T I I F Y I R R T
U N R P R M W F N P L I T G A
I L A B E L I N G U A M N I C
B K E A A C N Y Q W M H E W I
L Y V K A Q A U L F N M R W D
M C X T W I R I K O N K O P E
W G I N K B W D O V A K Q C M
H O Z C J B G T D P B B B S T
N O I T A I L I C N O C E R M

*COMMUNICATION
 MEDICATION
 RECONCILIATION*

*LABELING
 PARTNER
 IDENTIFICATION*

*INFECTION
 HANDOFF*



Could this Happen in Your Organization?

Patient Dies in Boston After Monitor Alarm Turned Off

A patient died last month after the alarm on a heart monitor was inadvertently left off, delaying the response of nurses and doctors to the patient’s medical crisis. Hospital administrators said they immediately began an investigation, which led them to inspect and disable the off switch on alarms on all of the hospital’s heart monitors within a day of the death. The hospital also has temporarily assigned a nurse in each unit to specifically listen for alarms, out of concern that sometimes even functioning alarms can’t be heard over the din of a busy ward.

Patient safety officials said this tragedy shines a spotlight on a national problem with cardiac monitors and other ubiquitous patient monitoring devices. Numerous deaths have been reported because alarms malfunctioned or were turned off, ignored, or unheard.

Dr. Lucian Leape, of the Harvard School of Public Health, said one key question for manufacturers is why they would ever make a machine that allows hospital staff to turn off a critical alarm. “Every piece of equipment we have has a failure rate, things go wrong,” he said. But “how come there are devices where this is possible? Why do you have a monitor you can turn off?”

Meyer said hospital administrators are not interested in assigning blame to individual staff members because that would be unfair and counterproductive in trying to encourage open reporting and discussion of problems. Rather, he said, hospital officials want to fix the underlying systemic issues with monitoring patients, which is why they disabled the alarms’ off switches.

To read the full article in the Boston Globe, go to:

http://www.boston.com/news/health/articles/2010/02/21/mgh_death_spurs_review_of_patient_monitors/

Complimentary reports and advisories on Clinical Alarms are available on our website (see [Tools You Can Use](#) page 3).



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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.



New Mexico
Hospital Association

TOOLS YOU CAN USE THE RADAR SCREEN FREE RESOURCES



MARK YOUR CALENDARS FOR NMHA 2010 ANNUAL MEETING

New Mexico Hospital Association's Annual Meeting will be held September 16-17, 2010 at the Hotel Albuquerque Old Town. Keynote speaker (scheduled) will be **Rick Pollack** Executive Vice President, Advocacy and Public Policy, American Hospital Association.

The Hotel Albuquerque is located at 800 Rio Grande Blvd., NW, in Albuquerque, 505-843-6300. NMHA group rate is \$129 per night.

Watch this newsletter for further updates on confirmed speakers and topics.

Looking for Templates for Employee Safety?

Downloads on employee training, templates, education, sample cleaning schedules for both physician office and hospital are available at:

<http://blogs.hcpro.com/osha/downloads/>

Health Care Leader Action Guide to Reduce Readmissions

The Health Research & Educational Trust (HRET) developed a free, downloadable guide for health care leaders to help start the conversation about how to address avoidable hospital readmissions. The guide is designed to serve as a quick, simple resource by outlining four steps:

- 1) Examine your hospital's current state of readmissions
- 2) Assess and prioritize your improvement opportunities
- 3) Develop an action plan of strategies to implement
- 4) Monitor your hospital's progress

Find it on NMHA's website: <http://www.nmhanet.org/quality/additional-resources/2010%20Reduce%20Hospital%20Readmission-Guide.pdf>

Free Reports and Advisories on Use of Clinical Alarms

Issues related to the use of clinical alarms are available from the Healthcare Technology Foundation and the Veterans Health Administration.

Find them on our website:

<http://www.nmhanet.org/quality/patient-safety/the-patient-safety-corridor-e-library/general-patient-safety>

March 2010 Pennsylvania Patient Safety Advisory

Topics include:

- Medication Errors with the Dosing of Insulin. Go to:

<http://www.patientsafetyauthority.org/EducationalTools/PatientSafetyTools/insulin/Pages/home.aspx> to view or download a sample tool that can be used to identify and monitor actual or potential problems with the use of insulin.

- Preventing Corneal Burns during Phacoemulsification — Surgical staff must be alert to any condition that could reduce delivery of saline, because compromised irrigation can lead to corneal burns.

- Wrong-Site Surgery Quarterly Update: This article provides an update on events of wrong-site surgery in Pennsylvania. Steady progress continues in preventing wrong-site surgeries with some curves along the way. Wrong-site local and regional anesthesia blocks are a major contributor of wrong-site operating room procedures.

[http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Mar7\(1\)/Pages/home.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Mar7(1)/Pages/home.aspx)

Institute For Safe Medication Practices Nurse Advise-ERR®,

A complimentary peer-reviewed newsletter published by the Institute for Safe Medication Practices (ISMP) is available at:

<http://www.ismp.org/Newsletters/nursing/backissues.asp>

Mechanical Ventilators in Acute Care Hospitals (cont.)

	Full Feature Critical Care Mechanical Ventilators Total Quantities	Full Feature Critical Care Mechanical Ventilators Per 100,000 Population	Full-feature Critical Care Mechanical Ventilators Pediatrics-capable	Full-feature Critical Care Mechanical Ventilators Pediatrics-capable Per 100,000 Population Under 18 Years Old
United States (excluding territories)	62274	20.5	33485	36.3
New Mexico	366	18.4	230	49.1
Texas	5419	22.3	1821	38.6
Arizona	1309	20.1	382	34.7
Colorado	913	18.5	521	43.2

Patient Safety Champions Word Search - KEY

G	N	S	H	H	M	V	D	N	S	E	D	J	U	V
Y	D	O	D	A	D	I	O	I	X	D	N	G	I	W
D	B	J	I	R	N	I	T	J	W	I	P	D	Q	A
Y	V	D	I	T	T	D	U	C	Z	E	E	Q	W	N
D	O	B	U	C	A	A	O	J	L	N	I	P	I	O
N	W	Y	E	H	O	C	I	F	T	B	V	A	Q	I
J	P	F	L	I	U	T	I	I	F	Y	I	R	R	T
U	N	R	P	R	M	W	F	N	P	L	I	T	G	A
I	L	A	B	E	L	I	N	G	U	A	M	N	I	C
B	K	E	A	A	C	N	Y	Q	W	M	H	E	W	I
L	Y	V	K	A	Q	A	U	L	F	N	M	R	W	D
M	C	X	T	W	I	R	I	K	O	N	K	O	P	E
W	G	I	N	K	B	W	D	O	V	A	K	Q	C	M
H	O	Z	C	J	B	G	T	D	P	B	B	B	S	T
N	O	I	T	A	I	L	I	C	N	O	C	E	R	M

COMMUNICATION
HANDOFF
IDENTIFICATION
MEDICATION

INFECTION
LABELING
REGONCILIATION
PARTNER