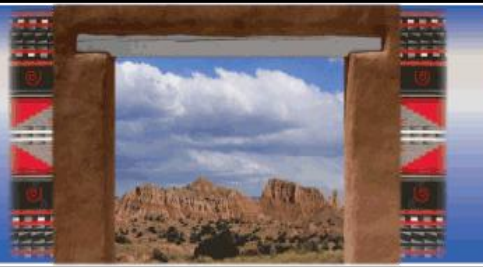




New Mexico
Hospital Association



Patient Safety Newsletter

Sin Daño – Without Harm January 2012

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You can really
change the world
if you care
enough.

- Marion
Wright
Edelman

NMHA is proud to
support the New Mexico
C. Difficile Infection
Prevention Project
(CDIPP)



Partnership for Patients

NMHA to Become Part of Hospital Engagement Network

NMHA is excited to announce that the Association has become a part of a Hospital Engagement Network (HEN) to assist New Mexico hospitals in improving patient safety in 10 targeted areas. With funding from CMS, NMHA and partners will work with the American Hospital Association/Health Research Education Trust (HRET) and 34 other state hospital associations to form the largest HEN in the country. Because the needs of individual hospitals are best understood by the state hospital associations, HRET will work through NMHA and partners to ensure that individual hospital needs and challenges are understood and

that each participating hospital receives the tailored improvement support that can help it to succeed. The goal of the Network is to reduce a set of nine conditions that cause patients harm by 40 percent and to reduce readmissions by 20 percent by the time the contracts end in 2014 or 2015 (see below for the 10 indicators). Participating hospitals will use process and outcome data for each targeted area to monitor their progress. The Network will provide a range of quality improvement support activities designed to meet participant needs. To date, twenty-three NM hospitals have committed to participation.

**What are
the
Hospital
Engage-
ment
Networks?**



The HEN contracts are being funded by CMS as part of the Partnership for Patients. Participating hospitals will use process and outcome data for each targeted area to monitor their progress. The Network will provide a range of quality improvement support activities designed to meet hospitals' needs.

Cont. on page 4

Joint Commission Issues Sentinel Event Alert on Worker Fatigue

Sentinel Event Alert Issue 48

Health care worker fatigue and patient safety

The link between health care worker fatigue and adverse events is well documented, with a substantial number of studies indicating that the practice of extended work hours contributes to high levels of worker fatigue and reduced productivity. These studies and others show that fatigue increases the risk of adverse events, compromises patient safety, and increases risk to personal safety and well-being. While it is acknowledged that many factors contribute to fatigue, including but not limited to insufficient staffing and excessive workloads, the pur-

pose of this *Sentinel Event Alert* is to address the effects and risks of an extended work day and of cumulative days of extended work hours.

The impact of fatigue

Fatigue resulting from an inadequate amount of sleep or insufficient quality of sleep over an extended period can lead to a number of problems, including:

- lapses in attention and inability to stay focused
- reduced motivation
- compromised problem solving
- confusion
- irritability
- memory lapses
- impaired communication
- slowed or faulty information processing and judgment
- diminished reaction time
- indifference and loss of empathy.

Contributing factors to fatigue and risks to patients
Shift length and work schedules have a significant effect on health care providers' quantity and quality of sleep and, consequently, on their job performance, as well as on the safety of their patients and their individual safety. This fact has been borne out in numerous studies. Findings from a groundbreaking 2004 study of 393 nurses over more than 5,300 shifts – the first in a series of studies of nurse fatigue and patient safety – showed that nurses who work shifts of 12.5 hours or longer are three times more likely to make an error in patient care. Additional studies show that longer shift length increased the risk of errors and close calls and were associated with de-

Cont. on page 4

CUSP Program Reduces Blood Infections in Alabama Hospitals

Alabama hospitals have reduced the number of bloodstream infections starting with a central line by 38 percent since joining a federal program last year, saving about \$1.5 million and almost 400 days in the hospital, officials with the Alabama Hospital Association said.

It also saved lives by preventing these dangerous and hard-to-treat infections, said Keith Granger, CEO of Trinity Medical Center and the chairman of the hospital group's Quality Task Force. According to the Centers for Disease Control and Prevention, almost 250,000 bloodstream infections occur in U.S. hospitals each year, often in patients who have a central vascular catheter, or a tube inserted into a large vein in the chest, which may be used to provide medication of fluids or check blood oxygen levels and other vital signs.

The Comprehensive-Unit Based Safety Program is focused on reducing central line bloodstream infections in intensive care units. It requires hospitals to institute a series of small steps, but the ultimate goal is to create what proponents call a "culture of safety."

Seventy-one Alabama hospitals with 83 intensive care units took part in the voluntary program, which started in 2009 but came to Alabama in July 2010.

For the year before the program started, Alabama hospitals had a 12-year average rate of 2.16 infections per 1,000. For the year since it began, that figure dropped to 1.34 per 1,000.

About 82 percent of the participating ICUs had no central line bloodstream infections for six months or more, and 43 percent went the whole year without one. Data for specific hospitals was not available but will be made public in 2012 through a partnership with the Alabama Department of Public Health, Granger said.

http://blog.al.com/spotnews/2011/10/program_reduces_blood_infectio.html

We Have a Sweetheart of a Webinar For You!!!!



As part of our Advocacy Agenda to support a health care work environment that emphasizes learning rather than blame, we offer a **COMPLIMENTARY WEBINAR** on the importance of an organizational **Just Culture**. A **Just Culture** seeks to judge the behavior, not the outcome, distinguishing between human error, at-risk behavior, and intentional reckless behavior.

GATHER YOUR LEADERSHIP TEAM

Join us for a webinar from Barbara Balik, RN, EdD
**Safe and Just Culture + Reliability =
 Doing Good and Doing Well**

Date: February 14, 2012

Time: 09:00AM -10:00AM VIA WEBINAR

The latest battleground in health care revolves around the patient experience. The epicenter of this battle, however, is being waged inside our organizations rather than between competing organizations. Consistently delivering the ideal patient experience can only be accomplished through the creation of an organizational culture that addresses quality in its three dimensions: clinical quality, service quality and quality of work life.

Purpose: Safety, Patient Experience, and Reliability are highly connected; offering senior leaders the opportunity to improve safety, experience, and financial vitality results with a common set of actions. This webinar will provide highlights of proven concepts and tactics to accelerate outcomes.

Audience: C-suite Healthcare Executives, Human Resources, Quality /Safety/Risk Leaders, Clinical Leaders and Educators

Join us in this complimentary introductory webinar by **Barbara Balik, RN, EdD**. Barbara is the Principal of Common Fire Healthcare Consulting, Senior Faculty at the Institute of Healthcare Improvement, and member of the National Patient Safety Foundation Board of Governors. Her areas of expertise include leadership and systems for a culture of quality and safety including patient-and-family centered care, patient experience, systems to improve transitions in care, and transforming care through electronic health record implementation and optimization. Barbara works with leaders to assure sustained improvement and innovation every day.

CLICK HERE TO REGISTER:

http://www.surveymonkey.com/s/NMHA_JUST_CULTURE_WEBINAR021412

Get Ready for Patient Safety Awareness Week March 4-10, 2012

Patient Safety Awareness Week is a national education and awareness-building campaign for improving patient safety at the local level. Hospitals and health care organizations across the country are encouraged to plan events to promote patient safety within their own organizations. Educational activities are centered on educating patients on how to become involved in their own health care, as well as assisting organizations to build partnerships within their communities.

For more information about how your organization can celebrate this important week, visit <http://www.npsf.org/hp/psaw/>



"Great spirits have always encountered violent opposition from mediocre minds"- Albert Einstein



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Please contact us if you would 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.nmhhsa.org/FileRequest?req=Compendium_of_NM_Patient_Safety_Best_Practice.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



When cameras are watching, hand hygiene improves

A new study found that more doctors and nurses washed their hands when video cameras were installed in every room in their unit and the staff was continuously informed about rates of hand-washing compliance.

<http://www.reuters.com/article/2011/11/30/us-doctors-wash-idUSTRE7AT2W520111130>

New medication reconciliation tool for hospitals

AHRQ has released a new toolkit to help hospitals improve their medication reconciliation processes to reduce adverse drug events. The Medications at Transitions and Clinical Handoffs (MATCH) Toolkit provides step-by-step instructions on how to improve a medication reconciliation process, from planning—including how to get leadership support—to pilot testing, implementation, and evaluation. Included is a workbook that helps users implement the Toolkit. The Toolkit is available at

<http://www.ahrq.gov/qual/match/>.

***Up and Away and Out of Sight:* program reminds parents to store medicines out of reach**

Almost 60,000 young children end up in emergency rooms each year because they get into medicines while their parents or caregivers aren't looking.

To address this public health risk, CDC initiated a public-private partnership, the **PROTECT Initiative**, aimed at reducing unintentional medication overdoses in children. A coalition of PROTECT partners is launching the *Up and Away and Out of Sight* campaign to educate parents and caregivers about three simple steps they can take to protect their children

The program reminds parents and caregivers to:

- store all medicines and vitamins out of reach and sight of small children
- completely close child-proof containers, and
- call Poison Control Centers at 800-222-1222 if children ingest drugs or nutritional supplements of any kind.

The program also provides free resources, including public service announcements, posters, tip sheets, videos, coloring pages and other materials for use in publicizing these vital messages.

Learn more about the program and CDC's poisoning prevention work:

www.upandaway.org

www.cdc.gov/safekid/poisoning

www.cdc.gov/MedicationSafety/protect/protect_Initiative.html

Institute of Medicine (IOM) posts *Patient-Clinician Communication: Basic Principles and Expectations*

In an era of increasingly personalized medicine and escalating clinical complexity, the importance of effective communication between the patient and the clinician is greater than ever. The IOM has posted a paper on basic principles that you can download from our website at:

<http://www.nmhanet.org/quality/patient-safety/the-patient-safety-corridor-e-library/patient-involvement/Patient%20Clinician%20Communication%20IOM%20June2011.pdf>

CMS Conditions of Participation available electronically (updated January 4, 2012)

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=8d913e8b899586bda7feaf12fce93076&rgn=div5&view=text&node=42:5.0.1.1.1&idno=42>

Electronic Code of Federal Regulations

e-CFR

TM

NMHA Part of Hospital Engagement Network (continued from page 1)

Who is HRET and how is it connected to NMHA?

The Health Research and Educational Trust is the nonprofit research and educational arm of the American Hospital Association. They are partnering with 34 state hospital associations to lead the largest HEN in the country. Because of its size, the HRET team has agreements from many of the foremost experts in each of the 10 targeted areas to provide improvement support to hospital participants.

The indicators are:

- Central Line-Associated Bloodstream Infection (CLABSI)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Adverse drug events
- Falls and immobility
- Obstetrical harm
- Pressure ulcers
- Surgical Site Infections (SSI)
- Venous thromboembolism (VTE)
- Ventilator-associated Pneumonia

(VAP)

- Preventable readmissions.

For more information on the Partnership for Patients, contact us Einterlandi@nmhsc.com

You can visit the CMS website: <http://www.healthcare.gov/compare/partnership-for-patients/> or the HRET website: <http://www.hret.org/>

Joint Commission Issues Sentinel Event Alert on Worker Fatigue (continued from page 1)

creased vigilance, and that nurses suffer higher rates of occupational injury when working shifts in excess of 12 hours. Still, while the dangers of extended work hours (more than 12 hours) are well known, the health care industry has been slow to adopt changes, particularly with regard to nursing.

“An overwhelming number of studies keep saying the same thing – once you pass a certain point, the risk of mistakes increases significantly,” says Ann Rogers, Ph.D., R.N., FAAN, a nationally renowned sleep medicine expert with Emory University’s Nell Hodgson Woodruff School of Nursing. “We have been slow to accept that we have physical limits and biologically we are not built to do the things we are trying to do.”

Actions suggested by The Joint Commission

There are some evidence-based actions that health care organizations can take to help mitigate the risks of fatigue that result from extended work hours – and, therefore, protect patients from preventable adverse outcomes.

For all organizations:

1. Assess your organization for fatigue-related risks. This includes an assessment of off-shift hours and consecutive shift work, and a review of staffing and other relevant policies to ensure they address extended work shifts and hours.
2. Since patient hand-offs are a time of high-risk – especially for fatigued staff – assess your organization’s

hand-off processes and procedures to ensure that they adequately protect patients.

3. Invite staff input into designing work schedules to minimize the potential for fatigue.

4. Create and implement a fatigue management plan that includes scientific strategies for fighting fatigue.

These strategies can include: engaging in conversations with others (not just listening and nodding); doing something that involves physical action (even if it is just stretching); strategic caffeine consumption (don’t use caffeine when you’re already alert and avoid caffeine near bedtime); taking short naps (less than 45 minutes). These strategies are derived from studies conducted by the National Aeronautics and Space Administration (NASA), which state that people can maximize their success by trying different combinations of countermeasures to find what works for them. The NASA studies stress that the only way to counteract the severe consequences of sleepiness is to sleep. Strategies for determining shift durations and using caffeine to combat fatigue can be found in chapter 40 of “Patient Safety and Quality: An Evidence-Based Handbook for Nurses.”

5. Educate staff about sleep hygiene and the effects of fatigue on patient safety. Sleep hygiene includes getting enough sleep and taking naps, practicing good sleep habits (for example, engaging in a relaxing pre-sleep routine, such as yoga or reading), and avoiding food, alcohol or stimulants (such as caffeine) that can impact

sleep.

Safety culture (for all organizations):

6. Provide opportunities for staff to express concerns about fatigue. Support staff when appropriate concerns about fatigue are raised and take action to address those concerns.

7. Encourage teamwork as a strategy to support staff who work extended work shifts or hours and to protect patients from potential harm. For example, use a system of independent second checks for critical tasks or complex patients.

8. Consider fatigue as a potentially contributing factor when reviewing all adverse events.

For organizations with a current policy that allows for sleep breaks for staff defined as essential by the organization:

9. Assess the environment provided for sleep breaks to ensure that it fully protects sleep. Fully protecting sleep requires the provision of basic measures to ensure good quality sleep, including providing uninterrupted coverage of all responsibilities (including carrying pagers and phones, and coverage of both admissions and all continuing care by another provider), and providing a cool, dark, quiet, comfortable room, and, if necessary, use of eye mask and ear plugs.

See relevant Joint Commission

requirements: LD.01.03.01 element of performance 5, LD.03.06.01 EP 3, LD.04.01.01 EP 2, LD.04.04.05 EP 13, PI.02.01.01 EPs 12-14, (hospital and long term care); NR.02.01.01 EP 1-6, NR.02.02.01

EP 1-4, (hospital)

http://www.jointcommission.org/sea_issue_48/