QUEST FOR EXCELLENCE

Organization:

Memorial Health Care Systems

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Topic and Category of Criteria:

Process Management/Organizational Performance Results

Memorial Health Care Systems (MHCS) is committed to providing quality of care for our patients in a safe environment. This commitment led by the Board of Directors and is reflected in our Strategic Plan. MHCS's Strategic Plan is comprised of seven Critical Success Factors (CSF) that together are designed to have a systematic approach to promote the quality outcomes for our patients and continued success of our facility. Specific action points are developed to fulfill the intent of the CSF. To ensure that each action point is addressed successfully, one or more individual is then assigned to each of the action points. Progress of each CSF is reported to the Board of Directors by the CEO on a quarterly basis with quality of care and patient safety as a major focus of MHCS.

One of MHCS's CSF is "Environment", which includes patient safety. In 2005 one of the action points that was assigned to the CSF Environment was the JCAHO National Patient Safety Goals. When JCAHO established these goals, they not only set the standards, but essentially sent out an invitation for all facilities to join rank to raise the level of patient safety in their facility. The Board of Directors accepted this challenge and assigned the responsibility of this action point to the Hospital Quality Council, which is comprised of the CEO and directors of all hospital departments.

The initial step that the Quality Council took was to educate all the members about the National Patient Safety Goals and why they are important to MHCS. A formal Performance Improvement Team was then commissioned with the assignment to evaluate MHCS's present compliance with the National Patient Safety Goals and to take action as necessary to promote compliance with National Patient Safety Goals as appropriate. The team hence became know as the Patient Safety Team.

MHCS utilizes steps from Six Sigma as the facility Performance Improvement model, *Define, Measure & Analyze, Improve, Control, & Re-evaluate.* Therefore this is the Performance Improvement model that the Patient Safety team utilized for this project.

DEFINE

The Patient Safety team is comprised of Theresa Schroeder, Manager of Laboratory; Trish Lenz, Director of Patient Care; Bonnie Hentzen, Manager of OR/OB/ER; Joan Kicken, Director of Pharmacy; Sharol Forsythe, Director Respiratory; and Kathi Kelly, Director of Quality Programs.

The Statement of Opportunity is: ***"JCAHO released the 2005 National Patient Safety Goals and we have the opportunity to be compliant with the goals through the work of a multidisciplinary team approach with the goal of promoting a safer environment for our patients".***

Measure and Analyze

The first step the team decided to take was to complete an inventory of what pieces of the National Patient Safety Goals MHCS had in place. The team designed an inventory tool and together the team members completed the inventory. The completed inventory tool is attached. Once the team identified the items that needed to be completed, the team elected to prioritize them, knowing that all of the items could not be addressed at the same time. The prioritized list the Patient Safety Team would work from was:

1. Patient Identification for treatment and procedures
    a. Two Identifiers
    b. Identification bands

2. Improving Effectiveness of Communication Among Caregivers

   a. Read Back Policy and Procedure

It was easy for the team to choose the patient identification as the number one priority to address. There had been two reported "near miss" incidents that involved patients with same names different dates of births, which had been caught and corrected by staff. Occurrences involving a wrong patient often results in serious consequences, potentially a sentinel event and therefore we elected to address this first. This is an indicator that is of high risk as opposed to high volume. This is a project designed for prevention of injury in the future as opposed to reaction to a problem or injury that has occurred. Therefore data is not a criteria for this project.

<u>IMPROVE/ACTION</u>

The Team selected the patient's full legal name and date of birth as the two identifiers to be verified prior to treatments and procedures at MHCS. A policy and procedure was written and staff was educated about the new policy and procedure. In conjunction with this training, the Patient Safety team educated staff about the National Patient Safety Goals. The team made and distributed posters about the National Patient Safety Goals. Along side the posters were note cards that had the purpose of the National Patient Safety Goals on one side and the actual goals on the reverse side. Staff was asked to read the card, complete the quiz on the back side, sign and date the card and turn the card in. Employees who completed the cards were eligible for a drawing. The employees thought this was great fun which resulted in excellent participation and

achieving our goal which was increasing staff awareness about the National Patient Safety Goals and the importance of patient safety.

CONTROL

The Patient Safety Team knew it would be important to verify staff's understanding of the policy and procedure of the two identifiers. The team waited for a couple of weeks after the training and then tested the staff. Each member of the team randomly selected ten direct staff care providers and asked them what the two mandatory identifiers are for verification for treatment and procedures at MHCS. If the employee gave the correct answer, he/she received a treat. The results were excellent with 97% of the staff answering the question correctly.

In the future the Patient Safety Team will monitor process control by occurrence reports. All services will complete an occurrence report for any variance that is noted relating to the required two identifiers for treatments and procedures. This data will be monitored by the Patient Safety Team and reported monthly to the Quality Council and quarterly to the Board of Directors.

The Patient Safety Team saw a need to extend the identification controls into the Emergency Room. The patients in the Emergency Room did not wear identification bands so in the event that we had multiple patients, it became difficult for the providers and care givers to track the patients. The team was also concerned about the patients leaving ER for tests in another department, such as Radiology, without any identification. The Patient Safety Team implemented the requirement that all Emergency Patients will wear identification bands. To ensure compliance, the Patient Safety team established a monitoring process by utilizing the existing occurrence

reporting process. The Radiology, Laboratory, and Respiratory Care Departments are asked to complete an occurrence report is they receive a request to perform a test and the patient does not have an identification band on. They will not complete the test until the band is applied. The occurrence reports are forwarded to the Director of Quality Department and reported to the Quality Council. This process was completed in August 2005 and reporting will begin this fall.

IMPROVEMENT/ACTION

As previously indicated the second goal to be addressed by the Patient Safety Team was communication, specifically receiving orders from providers. In June 2005, the Director of Patient Care, Trish Lenz went to a medical staff meeting and visited with the physicians about the importance of the nursing staff needing to clearly understand the orders that they receive verbally/telephone from the provider. She also discussed the importance of the physicians ensuring that the nurse understands their orders. Trish explained that the best way to ensure that this is accomplished is for the nurse to read back the orders to the physician upon completion of receiving the orders. The physicians supported this effort. A "Read Back Policy and Procedure" was developed and the hospital direct care staff was educated about the policy and procedure. An initial audit demonstrated that re-education of the "Read Back Policy and Procedure" for staff will be required and a plan will be developed by the Director of Patient Care.

The results of the Patient Care Safety Team were forwarded to the Board of Directors on August 23, 2005.

RESULTS

In conclusion, MHCS's patients are safer because we now have a process in place to ensure their identity before treatment and procedures, verifying their legal name and date of birth. A random audit verified that staff has a good understanding of this policy and procedure.

The Patient Safety Team also improved communication and the safety of receiving telephone and verbal orders by implementing the "Read Back Policy and Procedure". We are able to promote safety changes throughout MHCS due to the commitment of our staff, Senior Management, Medical Staff, and the Board of Directors. It is ultimately our patients that receive the benefit from that commitment through their positive outcomes and reduced risk of injury, including sentinel event.

LESSONS LEARNED

The Patient Safety Team utilized fun and games when introducing the National Patient Safety Goals and the Patient Identification Policy and Procedure. The results were very positive in contrast to the results from the training of the "Read Back Policy and Procedure" where fun and games were not utilized. In the future the team will definitely continue to incorporate fun and games with our training methodology. The Patient Safety Team feels the interventions that they implemented are sustainable because of the ongoing monitoring and reporting system that is in place.

The Patient Safety Team continues working on the National Patient Safety Goals and will now move towards meeting the 2006 goals with the ultimate goal to continuously promote patient safety at Memorial Health Care Systems.

MEMORIAL HEALTH CARE SYSTEMS

QUALITY PROGRAMS DEPARTMENT
POLICIES AND PROCEDURES

TITLE: National Patient Safety Goals - Read Back Orders	**ORIGINAL DATE:**
AURTHORED BY: Kathi Kelly, RN, BSN, CPHQ **APPROVED BY:** ______________________________ **Director of Quality Programs** ______________________________ **Chief of Staff** ______________________________ **Chief Executive Officer**	**REVISION DATES:**
DISTRIBUTION FOR: All Hospital Clinical Departments	

POLICY

To ensure that all orders and alert values are communicated correctly.

PROCEDURE

For verbal or telephone orders or reporting of critical test results include:

1. The physician or person providing the order or critical test result will state the order/test result.
2. The person receiving the order/alert test result will write the order/alert test result.
3. The person receiving the order/alert test result will read back the order/alert test result.
4. The physician or person providing the order/alert test result will state agreement or provide correction to the information read back.
5. The person receiving a physician order will document it as follows:
   T.O or V.O./RB/Dr. _____/person receiving, initial of first name with last name and credential(s). The “RB” verifies that the order/alert test result was read back with approval.
6. If someone is providing the order on behalf of a physician, his/her name follows the physician’s using the first name initial with the last name. In the event the person refuses to give their last name document the name provided.

2005 NATIONAL PATIENT SAFETY GOALS

DECEMBER 17, 2004 – Inventory Tool

Goal	Things In Place	Comment
1) Use at least two identifiers (neither the patient's room #) whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.	➢ Arm Bands ➢ Not used in all areas, i.e. ER	There are some problems with the arm bands: ➢ Not always on ➢ Not always accurate ➢ Not always the correct one Lab staff uses the armband info to label the tubes.
2) Improve the effectiveness of communication among caregivers… 1. For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result. 2. Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization. 3. Measure, assess and if appropriate take action to improve the timeliness of repotting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.	1. Nursing and pharmacy does read back sometimes but is "hit & miss" and not consistent. 2. Nursing does have a list of abbreviations not to be used, but is not being utilized.	1. Neither have a policy for "read back" so will need to develop one. 2. Will need to revise and add to it and get physician buy in. Joan will look for preprinted lists. 3. Need to define "timeliness" for lab and what is an alert value – is communicable disease alert? Radiologists do call the results of stat requests to the physician.
3.) Improve the safety of using medications… 1. Remove concentrated electrolytes (including, but not limited to, KCL >.9%) from patient care units. 2. Standardize and limit the number of drug concentrations available in the organization. Identify and at a minimum annually review a list of look-alike/sound alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.	1. Pharmacy limits the concentration. IVs are not to be prepared out of pharmacy area. 2. Formulary is routinely updated through the P&T Committee.	1. Joan wants to train and competency test the nursing staff mixing IVs. 3. Joan will look for some lists.

4.) Improve the safety of using infusion pumps sure free-flow protection on all general use and PCA intravenous infusion pumps used in the organization.	New pumps were recently purchased and training completed. They do have the free flow protection.	**Done**
5.) Reduce the risk of health care-associated infections… Comply with current CDC hand hygiene guidelines Manage as sentinel, events all identified cases of unanticipated death or permanent loss of function associated with a health care-associated infection	Hand Hygiene P&P in place	KK will review the CDC criteria to ensure no changes.
6.) Accurately and completely reconcile medications across the continuum of care. During 2005 develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list. A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.		Assisted Living is required to have a list as well.
7. Reduce the risk of patient harm resulting from falls. Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any risks.		