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The Patient Safety Act Signed into Law

University of Connecticut Health Center

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Collaborative Center for Clinical Care Improvement

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It's the Law

On July 29, 2005, President Bush signed the *Patient Safety and Quality Improvement Act of 2005* into law. All of us who are working to provide a safe environment—for both patients and employees—as well as a culture that stresses high quality of care for our patients at John Dempsey Hospital—are delighted with the signing of this new law.

How Does the Law Help?

This new law will allow hospitals, physicians, nurses and all health care workers to create a system for the voluntary reporting of medical errors and "near misses." These reports will be sent to a patient safety organization for ***the sole purpose of collecting and analyzing this information to improve patient safety.*** The new law provides protections for those employees who report patient safety information.

Background

A report released by the Institute of Medicine in 1999 called *"To Err is Human,"* pointed out that medical errors contributed to a large number of patient deaths each year. The report suggested that more people die from medical errors than from motor vehicle accidents or breast cancer in a year. According to the report, there were many issues related to patient safety that needed to be improved, such as:

- Reducing the number of mistakes in the medicines that patients receive while in the hospital
- Reducing the number of injuries patients get when they fall out of bed or slip and fall while walking around their hospital room
- Reducing the number of infections that patients get while they are in the hospital for the treatment of another condition

Since the report was released, there has been a lot of pressure on Congress to provide a way for information about patient safety issues to be collected and analyzed, in the hope that our hospitals and clinics could figure out why these mistakes were happening and then make changes that would make our hospitals safer for both our patients and our employees.

What Do We Have in Place at JDH to Support This New Law?

- **The Collaborative Center for Clinical Care Improvement (C4I)**
  Our mission is to make John Dempsey Hospital the safest hospital in Connecticut.
- **The "Good Catch" Award**
  To date, almost 30 employees have submitted their "Good Catches." Seven were announced in our February newsletter, and 15 more are announced on page 2. More are currently under review and will be announced in July. All 21 award recipients will receive certificates and "Good Catch" lapel pins at the May 16 UConn PRIDE/PAWS ceremony "Under the Tent."
- **The Patient Safety Committee**
  The Patient Safety Committee's responsibility is to review best practice for providing the safest patient care. This group also reviews all reports of near misses/good catches.
- **The Hospital Quality Resource Management (QRM) Committee**
  The Hospital QRM Committee reviews performance improvement efforts throughout the hospital and identifies clinical practice issues for performance and safety review.

The Collaborative Center for Clinical Care Improvement ("C4I") is dedicated to making John Dempsey Hospital the safest hospital in the State of Connecticut. We'd like your feedback and comments! Call us at Ext. 7650
James O. Menzoian, MD and **Rhea Sanford, RN, PhD, CS**—Co-Directors

"15 New Good Catch" Award Recipients

We thank the following individuals for sending us their "Good Catches"

Thanks to a "Good Catch" by **Diane Flanigan, RNC, Surgery 7,** work has been coordinated with Pharmacy to distinguish the packaging on two different IV drugs that had similar packaging.

Two more "Good Catches" by **Sandra Byrnes, RN, ICU,** addressed correct dosing for medications and ensured there was no duplication of medications administered.

Henry Wasik of Facilities contributed to patient safety when he intervened to prevent the accidental disconnection of a patient's oxygen supply. Good catch, Henry!

The staff from the Blood Bank:

Christine Cerniglia
Lisa Cruz
Bilonda Diyoka-Saleh
Alissa Ives
Julie Johnson-Burne
Kathy Peasley
Mary Piorkowski
Joan Stasiak
Marilyn Sundra

consistently ensure that all blood samples are properly labeled so that patients always receive the correct blood type.

Thanks to a "Good Catch" by **Diane Morgan, RN, OB-GYN,** better separation of different IV fluids will be reviewed.

Heidi Underhill, RN, OR reported her "Good Catch" in making sure a correct UCHC patient ID band was in place.

Mary-Ann Mazanowski, RN, ED, found incidents of "S-A-L-A-D" (Sound-Alike-Look-Alike-Drugs) in the ED that have been reviewed by the Patient Safety Committee.

Congratulations to all and "Hey, Good Catch!"

The Patient Safety and Quality Improvement Act of 2005 Act Quiz

The Patient Safety and Quality Improvement Act of 2005 was signed into law in response to a report by the Institute of Medicine called "To Err is Human" that suggested that a large number of patients die each year because of medical errors.

True or False?

John Dempsey Hospital already has several systems in place to support the new law, and these include the Collaborative Center for Clinical Care Improvement (C4I), The "Good Catch" Award, the Patient Safety Committee, and the Hospital QRM Committee.

True or False?

The following items are <u>all</u> goals that of the new law:

- Reducing the number of mistakes in the medicines that patients receive while in the hospital
- Reducing the number of injuries patients get when they fall out of bed or slip and fall while walking around their hospital room
- Reducing the number of infections that patients get while they are in the hospital for the treatment of another condition

True or False?

Answers:
The answer to all of the questions above is "True."

TELL US ABOUT *YOUR* "GOOD CATCH"

How to submit a story:

There are many ways to submit your story:

1. Use the submission form—Call Ext. 7650 to have one sent to you
2. e-mail your story to Garthwait@uchc.edu
3. Call Ext. 7650 and dictate your story—it will be transcribed and a draft will be sent to you for review and corrections.

This newsletter is the collaborative effort of the C4I staff.

<u>C4I Announcements</u>

- **Upcoming Newsletters:**
  June—Pain: Alternative Treatments
  July—Performance Improvement Measures
- **The C4I Website is currently under development! Watch for a Broadcast message with a website link soon!**