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Collaborative Center for Clinical Care Improvement

"Patient Safety Alert"

A New Way to Share Patient Safety Information Among Departments and Units

Communication

If there is one topic that comes up over and over again as we discuss ways to make John Dempsey Hospital the safest hospital, it is "communication." In fact, several of the 2006 and 2007 National Patient Safety Goals are centered around improving the effectiveness of communication among caregivers. There are many ways of doing this, and we have implemented several already. These include hand-offs, medication reconciliation, "SBAR," etc. On page two, we will talk in more detail about hand-offs and the use of "SBAR."

The C4I Medication Safety Group

At a recent meeting of the C4I Medication Safety Group, one of our physicians talked about a situation where he knew that one of our pharmacists, Gary Neilan, identified a problem with a printed form that had the potential for patient harm. He wanted to get the word out to all the inpatient units, but was not sure how to go about it. The group felt that this was an ideal opportunity to work on communication within JDH, so we have developed the "Patient Safety Alert" e-mail system.

An Example of a Patient Safety Alert

"I am writing to bring to your attention a situation which was detected by one of our pharmacists. One of our medication order forms is printed on non-carbon form with a white page and a yellow copy. The white page is kept on patient's clipboard and the yellow copy goes to the pharmacy. In this particular instance, white and yellow pages of the form were misaligned so that the print on the yellow copy was slightly lower than it was on the white page. As a result, the amount ordered for a particular medication on the white page was checked off on the wrong line in the yellow page. Fortunately for us, our pharmacist noticed this. He also scrutinized 200 or so other copies of the form and found 5 or 6 which were also similarly misaligned and destroyed them. Had the potential error gone unnoticed, it could have caused a potentially harmful event. I am sure similar forms are being used in other parts of JDH and thus I am writing to you so that this info can be shared."

C4I can now alert other units and staff to check the alignment of carbonless forms. Not only did this communication keep our patients safe, it enhanced communication throughout the hospital. We already knew that working together would help make us the safest hospital in Connecticut—this was a great example!

Brand New: "Patient Safety Alert"

The C4I Medication Safety Committee is pleased to announce a new process for submission of patient safety concerns that staff feel need to be shared with other units/departments.
Please send any such concerns to the following e-mail address in the Global listing:

"Patient Safety Alert"
(patientsafetyalert@exchange.uchc.edu)

C4I will make sure that the information is shared appropriately.

Who Will Get the Patient Safety Alerts?

On a case-by-case basis, C4I staff will decide how widely the information needs to be shared. Our hope is that these alerts will be discussed in staff meetings, added to patient safety boards throughout the hospital, and changes implemented where needed. Also, depending on the situation, there could be a "Good Catch" award for the person who sends in the alert.

Another Communication Initiative

Hand-Offs

A "hand-off" occurs when we transfer responsibility for a patient's care from one physician to another, one nurse to another, among other personnel, or when a patient is discharged from our hospital. We need to provide *complete and accurate* verbal communication about the patient's status and care. An easy-to-remember format for communicating with other caregivers is a technique called **"S-B-A-R,"** which stands for:

Situation: Identify yourself and your unit. Give the patient's name, identifying information, and the patient's current status (include medications, allergies, IV fluids, and recent lab results).

Background: Give the admission diagnosis, the date of admission, the pertinent medical history, brief summary of treatment to date.

Assessment: Provide the most recent vital signs—BP, pulse, respirations, temperature—and other applicable information such as mental status, skin color, pain level, wound drainage, respiratory rate/quality, rhythm changes, GI/GU symptoms (nausea, vomiting, diarrhea, output), musculoskeletal observations, etc.

Recommendation(s): State what you would like to see done (i.e., transfer the patient to the ICU, ask for the physician to see the patient now, ask for a consult, order tests, how often vital signs should be checked, etc.).

Communication Quiz

1. Improving the effectiveness of communication among caregivers is a topic that is included in the 2007 National Patient Safety Goals.

   True or False?

2. If you become aware of a situation that affects patient safety and you feel it is something that should be shared with other units and/or departments, you can send an e-mail to "Patient Safety Alert" and the C4I Department will make sure this information is shared appropriately.

   True or False?

3. SBAR stands for "Situation-Background-Assessment-Recommendation" and is a format for remembering all the elements of giving a good report on a patient's condition.

   True or False?

The answers to all of the above questions is "True."

From the C4I Handwashing Committee:

JUST ASK

We at JDH want to be a LEADER in Healthcare Hygiene with 100% compliance with hand washing before and after direct patient contact. We can do it!!

The C4I Handwashing Subcommittee recently launched the "JUST ASK" campaign. The objective of this program is to empower patients and visitors to ask any care giver if they have washed their hands. You will begin to see signs posted on patient doorways, in visiting rooms, on entrance doors to the nursing units and on personnel ID badges.

So, don't be insulted if someone should "JUST ASK"; they are doing their job. Now we are asking you to do your job and get those hands clean!!!

UHC Patient Safety Net® Update

On October 25 and 26, 2006 training will take place for managers, assistant managers, and other designated staff on the use of UHC's "Patient Safety Net®," a new system for reporting adverse events. We anticipate that this new system will be in use by November 1, 2006. This will replace the use of "RIR" forms (Risk Identification Report) in most patient care areas.