‘SafetyCounts’ one year later

By William Doherty, MD, and Maureen Pierog, RN
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Last year, Hallmark Health System (HHS) kicked off a broad “SafetyCounts” campaign to support and communicate our mutual and ongoing commitment to patient safety. Building on a solid foundation in patient safety and quality and our track record of results, we are seeking to bring patient safety to the next level. Patient safety is a major HHS initiative and is strongly supported by the HHS Board of Trustees and CEO Mike Sack.

One way we’ve tried to do this is through establishing a Culture of Safety Leadership Committee (we are listed on the back page) comprising HHS leaders whose work is rooted in safety and quality. Our goal is to organize and coordinate the many efforts underway to improve patient safety and promote a culture of safety in which everyone is engaged in thinking and talking about ways to improve care and keep patients, visitors and staff safe.

Our most visible “product” has been this newsletter. In the past year, we’ve written about everything from RMPro and preventing falls to handwashing and “bystander apathy.” Each issue includes a case study in which we present a potential patient safety issue that was recognized, reported and remedied at HHS.

We’ve also championed a number of other initiatives, including:
- a 2014 “Lunch and Learn” series focused on patient safety
- revising the employee standards of behavior to place safety at the top

While much has been accomplished, we have much more to do. We know that communication plays a major role in the delivery of safe and reliable health care; we hope that this theme will continue in the coming year. And we are always looking for your feedback about what we can do together to improve patient safety across our organization.

CASE STUDY

‘Two patient identifiers’ is national patient safety goal

Patient: “You’ve been taking care of me for three days and you know me. So why do you keep asking my name and when I was born every time you come in here?”

Nurse: “It’s one of the main things we do to keep you safe.”

Accurate patient identification is goal #1 among The Joint Commission’s National Patient Safety Goals for 2014. The way Hallmark Health System (HHS) achieves this is to ask a patient’s full name and date of birth every time the patient is to receive a treatment or service and match that treatment or service to the patient.

“This is not just a nursing policy,” said Risk Manager Debra Wright, RN, MPH, CPHRM. “It’s a policy for every encounter that involves administering care.”

While it may seem repetitious for patients and staff, the rationale for using two patient identifiers at every point of care is to eliminate “wrong-patient” errors that can occur during diagnosis and treatment.

Such errors are not uncommon and have been cited frequently as a cause of serious events nationally. “Perhaps the most common cause for confusion is similar names,” said Wright. “We recently had a situation in which one patient received a test intended for another patient with a similar name. That’s why we need to remain vigilant about checking the two patient identifiers so we can eliminate this type of error.”

At HHS, the goal is to check the two patient identifiers 100 percent of the time. “This can be done either by asking the patient his or her full name and date of birth or, if the patient isn’t able to answer verbally, to verify the information using the patient’s wristband ID,” added Wright.

Do you have a safety story to share? The SafetyCounts team wants to hear from you. Email us at safetycounts@hallmarkhealth.org.
MobiLab stops labeling errors at the bedside

Think about the last time you rented a car. An employee with a hand-held device probably checked you out and back in again, even printing a receipt.

A similar technology is at work with MobiLab, a wireless specimen collection system that’s been used at Hallmark Health System (HHS) since 2012. MobiLab uses bar code scanning and bedside label printing to ensure correct patient identification and accurate labeling of blood, urine and other samples.

More than 150 staff at HHS – primarily phlebotomists, nurses, clinical associates and nursing assistants – have been trained to use MobiLab on the inpatient floors and in the Emergency Departments and Urgent Care Centers. The devices – both hand-held and laptop versions – are used to collect specimens from more than 100,000 patients annually.

How does MobiLab help protect patient safety? “When MobiLab is in use, we have no labeling errors,” said System Director of Laboratory Services Michael Biskup. “The phlebotomist or nurse takes the device to the bedside and scans the patient’s wristband ID. Orders pop up for what specimens need to be collected and labels for the collection vessels print out. There is no question of mislabeling.”

The system has a number of checks and balances, including the need to re-scan the patient’s wristband ID after the specimens have been collected. MobiLab also interfaces with HHS’s Meditech hospital information system so the labs can upload and download information as needed. “Besides improving positive patient identification, MobiLab gives us accurate data compared to our previous manual process,” said Biskup. “This has helped us with workflow and productivity.”

Stressing medication reconciliation in outpatient care

Comparing a hospitalized patient’s home medications with those to be given in the hospital – called medication reconciliation – is an important patient safety measure. It’s also important in the doctor’s office.

Why? The main reason is that there are so many more physician office visits (an estimated 1 billion) compared to hospitalizations (an estimated 35 million), according to the Centers for Disease Control and Prevention. There are other reasons, too: patients often are prescribed medications by specialists they see in addition to their primary care physician, and they sometimes misunderstand how and when to take their medications or how their medications can interact.

To improve medication safety for outpatients, Hallmark Health Medical Associates (HHMA) participated this year in the “PROMISES Project” through the Massachusetts Department of Public Health and the Massachusetts Coalition for the Prevention of Medical Errors. Jadien Walter, BSN, RN, ambulatory risk manager, is working with the HHMA primary care practice of Regine Tillmanns, MD, in Melrose as a “PROMISES” coach to teach improvement skills.

“Most of our practices have some system to ask patients about their medications, but there is room for improvement of the process,” said Walter. “We hope to devise a simple system that will work for all practices and we’re using Dr. Tillmann’s practice as our pilot.”

In the pilot, patients are asked to review a printed list of their medications while they are waiting to see the doctor. A medical assistant then inputs any changes into the patient’s record and the updated list is then available for a doctor-patient conversation during the appointment. Patients with complicated medication regimens are asked to bring in all their medications to the visit.

“Most patients do this and find it helpful to review medication bottles together with their provider,” said Tillmanns. “This gives us a chance to detect errors, simplify the medication regimen and educate patients on their medications. It has been very eye-opening to see how the simple method of reviewing a patient’s actual medicine bottles can eliminate detrimental medication errors.”

Join the SafetyCounts campaign. Speak up when you see an opportunity to improve the safety of patients, visitors and staff by submitting an RMPro report or speaking to your manager.

SafetyCounts is published by the HHS Culture of Safety Leadership Committee: Nancy Bittner, PhD, CNS, RN; Thomas Byrne, MD; William Doherty, MD (co-chair); Diane Farragher-Smith, RN, MSN, MBA; Diane Hanley, MSN, RN-BC, EJD; Lori Howley; Tessa Lucey; Alan Macdonald; Maureen Pierog, RN, (co-chair); Steven Sbardella, MD; Judy Thorpe, RN, MS, NE-C; Johna Wasdyke; Debra Wright, RN, MPH, CPHRM.

Copy is reviewed and approved by committee members.