

➔ Speak up for safety *Know what to do, then do it.*

If a pedestrian steps into the path of a car, you yell “Look out!” If you’re babysitting and little Johnnie gets into the Pine-Sol under the sink, you grab it and tell his parents of the danger when they get home.

The lesson is that noticing problems before someone gets hurt allows an opportunity to prevent harm. There are two ways to accomplish this at Hallmark Health System (HHS).

One is to speak up. “If you see anything that doesn’t look right to you, you have to speak up,” said Steven Sbardella, MD, HHS medical director for Quality. This goes for everyone, from attending physicians to nurses to maintenance staff. Speaking up can sometimes be immediate – “if a patient is about to receive the wrong medication, for example. Or, if not immediate, it can involve a chain of command such as going to your director or supervisor,” he added.



The other is to report it. *RMPPro*, HHS’s electronic safety reporting system, “is our one repository for all safety issues that affect patients, visitors, and staff,” said Martha Krache, RN, MPH, who oversees risk management. “We receive about 4,000 reports a year but we know there are more incidents that are not reported.”

Issues may go unreported because staff members solve the problem right away and “they don’t recognize the need to submit a Patient Safety Report,” said Krache. Sending a Patient Safety Report of a near miss or close call “provides an opportunity to resolve a system issue before it affects a patient, visitor, or staff.”

The *RMPPro* database can sort through thousands of reports to identify themes and trends. One example is patient falls. “Falls used to be in the top three type of report, but because HHS has done a lot of educating around preventing falls, we have seen a dramatic reduction in the number of falls,” Krache said.

Adding heparin to Meditech pharmacy requests provides medication double check

Many patients treated at the Hallmark Health System Hematology and Oncology Center have a PICC line (peripherally inserted central catheter, or central line) or port (a vehicle for administering chemotherapy drugs) installed to ease the process of administering medications and blood draws.

But to improve accountability and patient safety, the Center’s staff worked to get heparin off the patient’s bedside table and back into the pharmacy. “Heparin is a prescription drug, and we wanted to build in another safety check by having it monitored through the pharmacy,” said Hamparian.

So heparin is now ordered through the Meditech health information system. “Once in Meditech, the order goes to Pyxis, our pharmacy automated drug dispensing system, and comes up from the pharmacy when needed, like all other medications,” said Ucheuma Obua, BS, PharmD, pharmacy clinical coordinator.

The new system was implemented a little more than a year ago and already has had an impact on patient safety. A case in point: a patient was admitted to

the Center from a long-term care facility, where a PICC line had been inserted. The facility neglected to tell the Center’s staff that the patient was allergic to heparin. “But because the pharmacy reviews everything, we were able to alert the staff to check with the facility and confirm the patient’s heparin allergy before any of it was dispensed and administered,” said Obua.

Said Hamparian, “We didn’t wait for harm to occur. We saw the potential for harm and created a safer process that already has enabled us to avoid at least one poor patient outcome.”

She added that “this is a great example of how teamwork and leadership – in this case, that of Elisa Scher, our patient care director for Oncology Services – can produce safe and improved outcomes.”



Tamar Hamparian and Ucheuma Obua

➔ CASE STUDY

Proper care of central lines and ports is essential, including keeping the lines clean and clear. Heparin is a prescription anticoagulant (blood-thinner) often used to slow the rate of blood clot formation. “But it’s also used to keep central and PICC lines clear,” said Tamar Hamparian, RN, BSN, OCN, infusion charge nurse. “After a patient’s treatment, we flush the lines with saline and heparin.”

Traditionally, pre-mixed vials of saline and heparin were readily available on the table right next to the patient during treatment. “In most cancer centers, this is standard procedure,” she said.

Do you have a safety story to share?
The *Safety Counts* team wants to hear from you.
Email us at safetycounts@hallmarkhealth.org.



➔ Patient handoffs: A safety 'best practice'

Team approach eases transition from ED, garners national interest

Last fall, Hallmark Health System (HHS) launched an innovative program to improve communication of patient information during the transition from the Emergency Department (ED) to the inpatient units, thus reducing the chance of errors and improving the quality of care.



About 80 percent of HHS's inpatient admissions come through the EDs. "We know from national studies that about two-thirds of medication errors occur during transitions of care," said Deborah Cronin-Waelde, RN, MSN, NEABC, system director of Emergency Services.

The new program is decidedly low-tech, but highly effective and extraordinarily collaborative. When a patient in the ED is ready to be admitted, a nurse from the patient's assigned floor comes to the ED and joins the "report," which takes place at the bedside. The handoff report process also includes the patient, any family members present, and the ED physician/physician assistant and nurse.

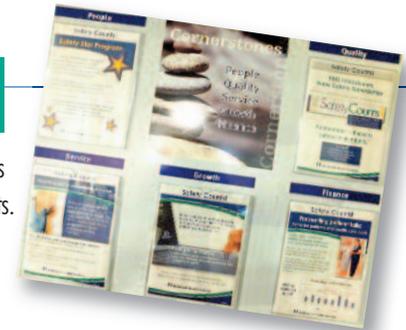
The bedside report includes completion of a checklist of essential information to provide a safe transition of care. The inpatient nurse then assumes the care of the patient, providing a seamless transition. "Although put in place to improve clinical quality, we've also received lots of positive feedback from patients and families," said Cronin-Waelde. "Not only do they appreciate hearing the report, they sometimes speak up and share with us clarifications of new information that is helpful in their care."

A similar best practice process was instituted in 2011 for change-of-shift reports on the inpatient floors, which now occur at the bedside rather than at nursing stations. "Our data already is showing that these practices are improving care and reducing the chances of errors and harm."

The inpatient and ED teams are proud of their work and were able to present it at the American Nurses Association conference in February. "Since then, we've gotten inquiries from around the country asking how they can get started on this new best practice model," she said.

➔ Take the cornerstone board quiz!

The current Cornerstone Boards are all about patient safety. Check out the boards, take the quiz opposite and submit your answers to safetycounts@hallmarkhealth.org by September 6. Be in the running to win special "SafetyCounts!" ID lanyards and flashlights. Winners will be chosen at random from among the entries with correct answers.



1. How do you login to *RMPPro*?

- a. Go to the internet
- b. Look for the Globe icon on your desktop
- c. Go to the HHS website
- d. Access it from your mobile device

2. How many Hallmark Health System patients are reached through post-discharge calls to discuss medications, follow-up appointments, and questions regarding their care?

- a. 90%
- b. 75%
- c. 95%
- d. 65%

3. Approximately how many falls per 1,000 patient days below the national mean was Hallmark Health System from October to December 2012?

- a. 0
- b. 5
- c. 3
- d. 1.5

4. What is *Safety Counts*?

- a. A new newsletter about patient safety
- b. A system-wide campaign to support and communicate our ongoing commitment
- c. An important component of creating a "culture of safety" at Hallmark Health System
- d. All of the above

5. Who do you contact if you want to submit a colleague for consideration as a "Safety Star" (fill in the blank)? _____

Get on Board!

Join the Safety Counts campaign and speak up when you see an opportunity to improve the safety of patients, visitors, and staff.

 **Hallmark Health System**



Safety Counts is published by the HHS Culture of Safety Leadership Committee: Thomas Byrne, MD, William Doherty, MD (co-chair), Diane Farragher Smith, RN, Nancy Gaden, RN, Diane Hanley, RN, Martha Krache, RN, MPH, Tessa Lucey, Alan MacDonald, Joanne Marqusee (co-chair), Maureen Pierog, RN, Diana Richardson, Steven Sbardella, MD, Johna Wasdyke. Copy is reviewed and approved by committee members.