

➔ Cornerstone Academy session focuses on safety Safety guru John Nance is keynoter

Statistically, a hospital stay is riskier than an airline flight. It's been shown that hospitals that adapt and implement the kinds of safety checks and procedures used in the airline industry can measurably improve patient safety.

This was the main theme of the Hallmark Health System (HHS) Cornerstone Academy on Oct. 30, attended by nearly 250 managers, physician leaders and members of the HHS Board of Trustees.

John Nance, a respected expert on aviation and patient safety, was the featured speaker. Many of his remarks were based on his book *Why Hospitals Should Fly*. Among the key take-away lessons from this Cornerstone Academy were:

- We must create a culture in which everyone feels empowered and supported in speaking up without fear of retribution if they are concerned about a potential issue

that could cause harm.

- Reporting of errors or "near misses" is not grounded in failure but in improvement. The aviation industry's robust reporting system of what could go wrong has proven to be a key element in airline safety improvements.

- All of us should see ourselves as leaders in the area of patient safety, "and be the kind of leader others – including yourself – would want to follow," said Johna Wasdyke, HHS director of Human Resources and a key organizer of the event.

- Know harm and do no harm.

The day-long event also included a screening of the documentary film *Chasing Zero: Winning the War on Healthcare Harm*, hosted and narrated by actor Dennis Quaid,



Keynoter John Nance proved to be an effective and inspirational speaker on patient safety, the theme of the day-long 2013 Cornerstone Academy session.

whose newborn twins nearly died from a medication error. The film supports a call to action for health care leaders to create systems that protect patient safety. The 50-minute film is available for viewing in department meetings and as a link on *NetLearning*.

➔ CASE STUDY

Employee recognized and fixed potential danger from maternity windows



Carpenter Dave Nelson (top) and his safe-window solution (inset).

Across the U.S., more than 5,000 children are injured each year after falling from windows, and young children are most at risk.

Dave Nelson probably didn't know this statistic, but he did know a potentially dangerous situation when he saw one. And he did something about it – within days.

Hallmark Health System (HHS) Director of Engineering and System Safety Officer Justin Ferbert tells the story of Dave Nelson, an HHS carpenter and locksmith.

Earlier this year, Dave was on Maternity 6 at Melrose-Wakefield Hospital and was asked by a family with small children who were visiting a new mom to help them open a window to get some fresh air. Typically, windows in a hospital aren't operable, both for safety and energy-efficiency reasons. But in some cases – trying to

balance these factors with positive patient experience – windows can open, usually with permission and with a hospital employee helping to open them.

On Maternity 6, the windows opened all the way. Dave determined that this posed a safety hazard, particularly because young children often visit the unit. So within a couple of days, he installed blocking mechanisms on all 20 or so windows so they can't open more than 3 inches.

Diana Richardson, HHS vice president for Facilities, Support and Professional Services, added that "as a result of this, we reviewed other windows as well and did the same retrofit to the windows on the Labor and Delivery Unit on the second floor. Thanks to Dave for spotting the potential hazard and making sure it got resolved."

Do you have a safety story to share?

The *SafetyCounts* team wants to hear from you.
Email us at safetycounts@hallmarkhealth.org.





Electronic surveillance helps prevent infections

Software tracks and identifies data on patient infections



Imagine an employee whose job description is to search for patients in the hospital who might have infections. That would make the hospital a safer place for patients, staff and visitors, right? But given the numbers of patients in a hospital, to do it right would take many employees and still they might not see a pattern.

At Hallmark Health

System (HHS), those “employees” aren’t people but a software program called *MedMined*, which HHS implemented last year. Since then, it has provided automated infection surveillance support to HHS infection control nurses Elaine Boerger, RN and Sue Rowland, RN, CIC. The software is helping improve infection prevention processes, reduce the incidence of hospital-acquired infections and assess the impact of their infection control efforts.

It works by sifting electronically through lab data generated from literally tens of thousands of patient cultures and sends information to the nurses based on culture results.

“It’s a huge advantage to be able to get an early alert to an infection or pattern of infection that wouldn’t have been visible in the paper-based system we were using before,” said Maureen Pierog, HHS vice president for Quality. “We’re now able to dig deeper and more efficiently look for problems.”

Finding those patterns is one of the specialties of the system. “Say the system shows positive cultures for a number of patients in adjacent rooms,” said Boerger. “That’s a heads-up for us to investigate.” The reverse is true as well. “When we get negative cultures on all the patients on a nursing unit who have catheters, for example, we can go congratulate the staff there.”

The system can track and catalog infections that must be publicly reported. It can pinpoint potential problems in areas the infection control team wasn’t able to monitor before. And its protocol library is a back-up resource for the team when dealing with an infection.

“Its biggest advantage,” said Pierog, “is that we are now made aware in a timely fashion of opportunities for improvement around potential or current infections so we can act on them quickly.”

Lisa Duffy, MS, RN, nursing director, W2 and ICU at Lawrence Memorial Hospital, confers with infection control nurse Elaine Boerger, RN, about MedMined results.



Interdisciplinary Clinical Practice Committee

Physician group seeks to improve safety across the board

M&M (morbidity and mortality) conferences are a part of the fabric of organized medicine and have been since they were established in the early 1900s as a way to evaluate patient care. Fortunately, they are no longer like the TV version with senior physicians berating others to “shame” them into providing better and safer care. Such an atmosphere does not create a culture of safety and does not result in providers learning to improve care. Intended as a confidential peer review discussion of medical errors or near misses in the care of patients, the conferences have become an important learning tool for physicians everywhere.

At Hallmark Health System (HHS), several departments hold their own M&M conferences. But HHS clinical leaders wanted to take the concept one step further and last year established an Interdisciplinary Clinical Practice Committee. Its aim is to improve patient care by providing a venue for clinicians to discuss cases, identify areas of improvement and promote professionalism, ethical integrity and transparency. Cases discussed in the group tend to be those that are



very complex, multi-disciplinary or involve multiple clinicians.

“The sessions are not just for physicians,” said Steven Sbardella, MD, who co-chairs the committee with Charles Allen, MD. “Also included are physician extenders, nurses and anyone else who was involved with the case.”

Discussions that occur at the committee focus on different approaches that may lead to a better outcome for patients presenting with similar issues.

“We want to create a comfortable environment in which everyone interested in the case feels free to engage in open discussion,” he added. “The point is for all of us to gain a better understanding of what happened and how to improve. The ultimate goal is that people will begin to feel really comfortable questioning each other during the processing of a patient.”

Clinicians gather to discuss improving patient care and safety at their monthly meeting. Videoconferencing enables participation from both campuses.

 **Hallmark Health System**

Get on board!

Join the *SafetyCounts* campaign. Speak up when you see an opportunity to improve the safety of patients, visitors and staff by submitting an *RMPPro* 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, Nancy Gaden, RN, Diane Hanley, RN, Tina Karas, 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.