

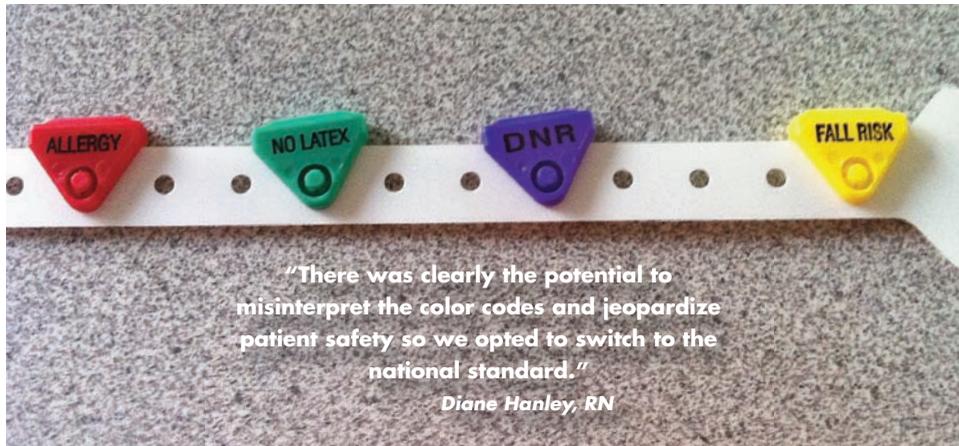
# SafetyCounts!

## ➔ New ID wristbands add 'charm' to patient safety

In late February, Hallmark Health System (HHS) inpatients started sporting new ID wristbands aimed at improving patient safety and comfort. The new wristband looks a bit like a charm bracelet with several snap-on, color-coded tabs to let clinicians know of special risks associated with the patient wearing it. The colors of the snap-ons reflect a national color-coding standard now used in most states in the U.S. (though not yet in Massachusetts).

The move to the national standard began at HHS in the Emergency Department (ED). "An ED nurse came to our Nursing Practice Quality Council and proposed that we change," said Diane Hanley, RN, associate CNO for Practice, Quality and Education. "She mentioned that some nurses in the ED also work at other hospitals that used a different color-coding system and so different

colors meant different things. There was clearly the potential to misinterpret the color codes and jeopardize patient safety so we opted to switch to the national standard."



The snap-on type of wristband was chosen, said Hanley, "because it is both color-coded *and* each tab has the name of the risk imprinted on it – on the purple tab, for example, it also says 'DNR.' Nurses seem to really like this improvement." Patients seem to like it as well since those with multiple risk

factors need to wear only one wristband.

The wristbands are assembled by nurses for each patient. "Each time a patient moves – from the ED to a patient floor, for example – the wristbands are checked again. And a new tab can be added if a new risk becomes apparent," said Hanley.

## ➔ CASE STUDY

### Wanted: Ideas to improve this patient's experience

As an organization, Hallmark Health System (HHS) works tirelessly to ensure a culture of safety and that each patient receives the highest quality of care through every interaction. This includes taking into account how a patient perceives the way care is being delivered. Recently, HHS President and CEO Michael Sack received a letter from a patient who said she arrived at the Emergency Department at 7 a.m., was told that she would be admitted, waited all day before she was brought to the floor, had trouble with an IV

and was awakened in the middle of the night for a blood draw. Her perception is that little was done to take care of her leaking IV or inform her of the time it would take to admit her to the floor. By the time she got to the nursing unit in the early evening, she was exhausted and then awakened at 3 a.m. for a procedure. She was discharged only to be asked to come back to remove her IV, which was done in a non-patient care area.

"This is an unfortunate example of a lot of things not going right for this patient," said Sack. "Good intentions did not get the job done. In a busy environment we can easily forget to consider how the patient feels and thinks."

Many of the activities that care providers experience as commonplace

are new to the patient and can be worrisome. How often was this patient updated around timing of her admission? When the IV issue was addressed, did staff take the time to address other concerns or fears that the IV problem evoked? Did staff talk with her about what to expect during the night?

How can HHS address issues that may impact patients' perceptions of care, including issues around safety, clinical care and communication?

Send suggestions to [safetycounts@hallmarkhealth.org](mailto:safetycounts@hallmarkhealth.org). HHS is committed to creating a culture of safety that not only provides exceptional care, but helps patients know they are receiving exceptional care.

#### We want to hear from you!

What are the patient safety issues here?  
What about clinical care procedures?  
What about communication? Are there other issues? Send your suggestions to [safetycounts@hallmarkhealth.org](mailto:safetycounts@hallmarkhealth.org).

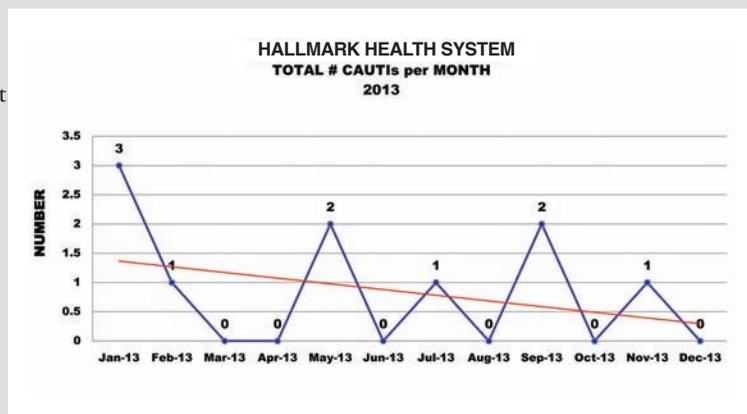




## Keeping CAUTI at bay: CMS-sponsored program helps cut catheter use and infections

CAUTI is the acronym for Catheter Associated Urinary Tract Infection, the most common of all hospital-acquired infections. In 2012, Hallmark Health System (HHS) joined the CMS-sponsored “Stop CAUTI” initiative to decrease urinary catheter usage and reduce the number of CAUTIs to zero.

Urinary catheters are placed in about 25 percent of hospital inpatients and many of these are not essential for a patient’s medical care. “We can’t avoid all urinary catheters,” said HHS Director of Quality and Patient Safety Kathleen Charbonnier, RN, BSN, CCRN, NE-BC. “The key is to place a catheter only when it is clinically indicated – for example, when monitoring urine output for a critically ill patient. Even when a urinary catheter is required for a patient’s treatment, the aim is to remove it as soon as it is no longer medically necessary. The longer a catheter remains in place, the more likely a CAUTI will develop.”



The goal for HHS is threefold: reduce the number of catheter insertions, develop a standardized catheter-removal protocol and eliminate CAUTIs. An interdisciplinary CAUTI team was formed and Med 3 at Melrose-Wakefield Hospital was chosen as the pilot site. The team provided education for all shifts. “We also redesigned our nurse-driven

catheter removal protocol and worked with IT to enhance catheter-related documentation in the EMR,” she said. Other improvements included daily catheter reporting, entering every CAUTI into *RMPPro*, and instituting a “tracer” system for monthly rounding.

While CAUTIs have not yet been reduced to zero, the team believes it is only a matter of time. “The hospital leadership, our nurses and physicians are all committed to the goal of zero CAUTIs,” said Charbonnier.



## Employees empowered through teamwork to prevent errors

Radiation therapy staff are expert planners. Patients with cancer visit the Hallmark Health System (HHS) Radiation Therapy Department several days before they actually begin radiation treatments. The goal is precision – to ensure that radiation is delivered to the exact area needed and no other.

At HHS, the radiation therapy team consists of administrative staff, nurses, physicist, dosimetrists, radiation therapists and radiation oncologists. “The physicist and dosimetrists are the ‘architects’ of treatment, who draw the blueprint for clinicians to use during treatment,” said Glenn Davis, HHS operations manager for Oncology.

Last summer, one of the dosimetrists noticed a discrepancy among the pieces of documentation for a patient’s planned treatment. “It was a left side/right side issue,” said Davis, “and, had it not been spotted, the patient could have received radiation on the wrong side.” The dosimetrist spoke up, asked for clarification to resolve which side was the target and submitted a “near miss” *RMPPro* report.

The key phrase here is “spoke up.” “Because everyone on the

radiation therapy team feels empowered to speak up – in the interests of process improvement instead of individual

blame – the mistake was caught and no harm was done,” said Davis.

And the key concept is teamwork. “No one is better than anyone else on our team,” he added. “We are all responsible for the series of checks and double-checks – through software, checklists and other tools – that ensure the quality of our work. And we are all very comfortable about raising questions and concerns when patient safety is at stake.”



Members of the Radiation Therapy Department work as a team to provide the best possible patient care.

### 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 Farraher-Smith, RN; Diane Hanley, RN; Lori Howley; Tina Karas; Martha Krache, RN, MPH; Tessa Lucey; Alan Macdonald; Maureen Pierog, RN, (co-chair); Steven Sbardella, MD; Judy Thorpe, RN, MS, NE-C; Johna Wasdyke.

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