January 2011 Vol. 12, No. 1

Patient Safety Monitor JOURNAL

Better teams, better checklists, better care

ICU project provides insight to nixing errors

Medication errors, patient identification errors, and surgical errors are some of the unfortunate events that take place all too frequently in healthcare. In the constant battle to prevent these adverse events, one word keeps cropping up: checklists.

Checklists were the focus of the October 27, 2010, PharmacyOne Source webinar, "Creating a Checklist Culture." The speaker, **Chris George, RN, MS,** is the project manager for the Keystone ICU collaborative at Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality, which leads voluntary collaborative projects to improve patient safety and quality and reduce costs.

The Keystone ICU collaborative has been striving to improve patient safety and reduce central line–associated bloodstream infections (CLABSI), ventilator-associated pneumonia (VAP), and other infections occurring in ICU patients. It remains the largest regional partnership of ICUs in a single patient safety initiative, executing a unit-based safety program and daily goals sheet, eliminating CLABSIs and VAP, evaluating ICU deaths, and evaluating ICU teams and their leaders who are successful in improving patient safety in the ICU, according to its website.

George discussed hospital-acquired infections (HAI) and how checklists can help hospitals avoid them. The four most common HAIs are VAP, surgical site infections, catheter-related bloodstream infections, and catheter-associated urinary tract infections. Together, these infections afflict an average of 1.7 million patients per year in hospitals and are the sixth leading cause of preventable deaths, George said. She noted that checklists can also help prevent wrong-site surgeries along with preventing HAIs.

> **"We work in a very hectic environment, and it's easy to overlook a process; you can be interrupted 10 times while trying to prepare a medication."**
>
> *—Chris George, RN, MS*

Why checklists?

The complexity of healthcare delivery, combined with new technology and new research that change patient care, means that clinicians have ever more complicated responsibilities, creating the need for checklists.

"It makes it really difficult for individuals to keep up, manage, and stay on top of things," George said. "We're trying to do the best we can, but the systems in which we are working are flawed and are set up to make mistakes and to not always provide the best care possible."

George recalled a case in which a surgical team didn't have blood on hold for a patient.

"When preparing for procedures, sometimes things are overlooked," she said.

In this case, blood was not put on hold for a patient prior to surgery, which is against normal protocol. After

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Checklists

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reviewing their checklists, OR staff realized the error. The surgeon believed the absence of blood on hold was not an issue. A nurse, however, went ahead and made sure blood was available, per the checklist. The patient ultimately developed a critical need for the blood. The checklist served as a vital reminder for staff to check for blood, empowering the nurse to speak up and obtain it, George explained.

Creating a good checklist

Lots of hospitals use checklists for various procedures, but not all checklists are created equal, George said. There are certain components that make up a good checklist. Checklists must be:

- Precise
- Efficient
- Easy to use in difficult situations
- A mix of tasks and communication checks

Checklists are reminders of the most critical steps in a procedure; therefore, they need to be easily understood, with no more than five to nine numbered items to avoid excess information, said George. It's also important to speak with staff who will be using the checklist to establish the critical steps that should be included. "The purpose isn't to take away from clinician expertise, but to remind us of commonly missed steps," she said.

Implementing better teamwork

For checklists to work, George said staff members must work cohesively as a team. For starters, George recommended that members of the care team call each other by their first names. This makes everyone feel part of a team and increases willingness to speak up, she said.

"In some cases, something has happened and the staff was aware something wrong was being done, but thought, 'It's not my job to correct the surgeon,' " George said. They may be embarrassed or worry about being reprimanded for speaking up, she added.

George discussed steps the Keystone ICU collaborative follows to achieve its current success, called the Comprehensive Unit-Based Safety Program (CUSP). CUSP is a five-step process that includes educating staff on safety,

Editorial Advisory Board *Patient Safety Monitor Journal*

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Group Publisher: **Emily Sheahan,** *esheahan@hcpro.com*
Managing Editor: **Tami Swartz,** *tswartz@hcpro.com*
781/639-1872, Ext. 3165

David M. Benjamin, PhD
Adjunct Assistant Professor
Department of Pharmacology & Experimental Therapeutics
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Questions? Comments? Ideas?

Contact Managing Editor
Tami Swartz

Telephone 781/639-1872, Ext. 3165

E-mail *tswartz@hcpro.com*

identifying defects, assigning an executive team leader, learning from defects, and implementing teamwork tools.

"We need to accept that we will make mistakes," said George. Rather than playing the blame game, it's important to focus on the system and let the team share its learning experience.

Identifying defects prepares staff and helps them engage in finding future solutions to benefit patient safety and care. Staff members know what potential patient safety hazards are, so when something goes wrong, it's important to identify the problems in order to prevent them from happening again. This step should be ongoing because events can be common.

George also emphasized the importance of assigning a senior executive to work with the team. Once he or she has been appointed, safety issues should be discussed.

"Some of these team leaders haven't spent time in clinical settings and they don't understand what it's like to be providing patient care," George explained. "It's very important that we pull them in in a way that is not threatening."

Senior leadership staff should try to meet monthly with frontline staff to better understand challenges they may face. Having this sort of partnership assists in accountability and breaks down any barriers that may have been in place.

Learning from the defects of a procedure is another important step. George suggested asking questions such as "What happened?" and "How do we prevent it from happening again?"

"It helps to have an organized approach to hazardous issues on a monthly or quarterly basis," she said. Staff must recognize how significant a system error might be.

Morning briefings, held before the day begins, can help kick-start better teamwork, said George. Teams can discuss their daily goals and even customize them in relation to their specific environment. Having a new staff member shadow a more experienced staff member helps new personnel learn what to look for and how to avoid hazards.

George acknowledged that work-arounds or noncompliance with checklists can happen easily. "We work in a very hectic environment, and it's easy to overlook a process; you can be interrupted 10 times while trying to prepare a medication."

Performing spot checks will help with compliance, George said.

The Keystone ICU project has saved more than 1,500 lives and $200 million statewide in healthcare costs, she noted. ■

Critical to your QI efforts: Engaging busy bedside nurses

Transparency is key

Editor's note: The following is an excerpt from the HCPro book Quality Improvement for Nurse Managers: Engage Staff and Improve Patient Outcomes, *written by* ***Cynthia Barnard, MBA, MSJS, CPHQ,*** *and* ***Barbara Hannon, RN, MSN, CPHQ.*** *Visit* www.hcmarketplace.com/prod-8500 *for more information.*

Improving nursing-sensitive indicators (NSI) or organizational indicators with a nursing component requires participation of direct-care bedside nurses. Quality improvement (QI) programs designed by organizational-level experts to improve patient care and driven down from the top will not succeed without buy-in from staff members closest to the patient. It is critical that nurses at the bedside are engaged in QI, carrying out the bundles, protocols, and other processes designed to improve quality and safety. Yet getting direct-care nurses involved in QI is difficult in many hospitals, as bedside nurses complain they are already too busy, they do not have enough staff members to carry out complex QI processes, or they feel QI

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Engage nurses

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is not in the scope of the nursing practice. Nurse leaders must create a culture of engagement in QI, keeping in mind the following concepts:

- QI must be meaningful to nurses and not seen simply as a regulatory requirement
- QI must be linked to professionalism
- The processes used in the protocols must be driven by best practice, and nurses must be able to see a direct link between nursing interventions and patient outcomes
- Nurses must understand (and accept) the data
- Nurses must be involved in the process of improvement and in identifying the interventions, action plans, and monitoring
- Nurses must see their efforts rewarded with improved data

Be transparent

Information and knowledge are crucial to staff engagement in meeting the strategic goals of the healthcare institution. Staff members will be engaged if they know the facts about their organization. In the past, some staff nurses were disengaged hospital employees, focused on patient care and knowing little about issues such as budget or operating margins or market share. Nurse leaders may even have promoted this attitude, rarely sharing budget-sensitive information with staff nurses. However, emerging insights from healthcare and other industries demonstrate that an engaged and informed workforce is crucial to deliver strong performance and efficiency. Nurses have a special role and opportunity in healthcare organizations as licensed professionals who can make an enormous difference in the success of the overall organization, its culture, teamwork, performance, and safety. In these tough economic times, there is a need for staff nurses to understand the issues facing their institution.

As valued employees who are integral to the success of their organization, nurses need to see that quality outcomes draw patients to their institution and increase market share. Likewise, they need to understand that poor outcomes may cost their hospital its reputation, as well as financial penalties, loss of managed care contracts, any indirect cost increases associated with inefficiency, rework, readmissions, etc. Continued employment may be at risk for nurses who work in hospitals with decreasing market share or budget difficulties. Therefore, all nurses need to know the facts about their institution (good or bad) and understand that it is their job to promote excellence. Nurse leaders need to share the following:

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- Operating and capital budgets, market share, and the role of labor cost in the budget
- Performance on key clinical and business metrics
- Strategic goals of the institution
- Market share
- Labor costs/margins
- Institutional strengths, new programs, and plans

The following is an example of how sharing this information can be helpful: The chief nursing officer (CNO) of a large hospital was told by the hospital CEO that he had to cut the nursing budget as the hospital had a budget deficit due to a decrease in patient census. The CNO shared this information for the first time with all staff nurses during multiple open forums, indicating that nursing positions might have to be cut unless increased census at the hospital occurred.

Staff nurses were shocked at the reality of the budget losses. Each unit, fearing fellow staff nurse cuts, created nursing-driven projects to improve patient satisfaction to ensure a continued census increase and continued employment. Staff nurses requested weekly updates from the CNO regarding how census and budget numbers were faring, creating a new climate of transparency in the nursing department.

Direct-care nurses and QI data

Nurse leaders also need to share benchmarks with direct-care nurses. Nurses want to know how their institution compares to others, especially hospitals in the same market area, on quality measures and NSIs. Nurses are interested and will be engaged in questions pertaining to their institution, such as the average length of stay for patients with certain conditions; whether patients experience more falls, more skin ulcers, or more cardiac arrests or deep vein thrombosis than patients at other hospitals; or whether patients are more satisfied with their nursing care than patients at other hospitals. Nurse leaders must share these data, good or bad, with their staff. In addition, it is important that nurse leaders inform their staff of the unit targets for improving data and engage staff to participate in establishing and monitoring targets for improving results.

How to share data with direct-care nurses

For the busy bedside nurse who does not have the time to view complex data report sheets, the use of colorful, simple graphs can be used to quickly demonstrate unit performance. For example, if you want to highlight a unit that it is staying within its targets for falls, you can graph falls on a control chart, showing the trends over time.

> **Information and knowledge are crucial to staff engagement in meeting the strategic goals of the healthcare institution. Staff members will be engaged if they know the facts about their organization.**

Control charts allow for monthly or quarterly data points to be placed, and the resulting frequency line can be viewed quickly by busy unit nurses to check their progress. Another way to show direct-care nurses how they are doing at the unit level is to use a unit scorecard.

The following is an example of how a nurse leader can share QI data to improve outcomes: The nurse manager of a medical ICU looked at benchmarked data regarding ventilator-associated pneumonia (VAP) rates in her unit compared to VAP rates in other hospitals in the state through the state hospital association. Analysis revealed that her unit's rate was one of the lowest in the state. Consequently, she asked the

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Engage nurses

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QI department to make a large, colorful graph showing her unit's low VAP rate against the average rate for all participating hospitals in the state. The nurse manager's staff were instantly able to see their performance. She posted the graph and made copies for her staff members for a unit staff meeting in which she praised them for adhering to the VAP bundles. Her staff showed pride in their accomplishment and vowed that the unit's VAP rate would be the "lowest in the state" by the next quarter. Nurse leaders can communicate information about and advertise how their institution is performing in a number of ways:

- Open forums for all nursing staff members
- Newsletters
- Broadcasts/podcasts
- Staff meetings
- Shared governance and quality meetings
- Posted scorecards
- Standardized graphs from benchmarks
- A weekly blog by the CNO ■

Fresh perspective

New year, new patient safety resolutions

*Editor's note: The following column explores patient safety from the perspective of a newcomer to the patient safety field. Columnist **Catherine Hinz, MHA,** currently works at PatientSafe Solutions, Inc. Previously, she served as the patient lead at HealthEast Care System in St. Paul, MN, worked for seven years as an ED health unit coordinator, and completed a patient safety internship with the Agency for Healthcare Research and Quality.*

As cliché as it might sound, the start of a new year brings a new opportunity to pause and plan for the 12 months ahead. Even though many of us run operations on a separate fiscal year, where budget planning takes precedence for new strategies and projects, I'm a firm believer that the beginning of the calendar year has the ability to revitalize and invigorate our energy, motives, patient safety culture, and strategic programming.

This year will no doubt be a difficult year in the healthcare industry. Activities on Capitol Hill and with state legislatures will surely affect daily operations inside our hospital and clinic walls. Regardless of whether congressional repeals or controversial votes occur on either side of the aisle, there is no doubt that some provisions of healthcare reform will drastically change our payment and delivery systems—subsequently changing the processes by which our clinicians practice medicine and patients receive care.

This challenging time reminds me of a communication I wrote for the 7,000 employees of the health system where I used to work. I wrote the piece at the start of a new fiscal year and in conjunction with the 10-year anniversary of the Institute of Medicine publication *To Err Is Human*. I addressed the slow (but steady) progress institutions have made.

I stated that there have been incredible advancements in technologies, devices, and the medications we use to treat patients. I argued, however, that the systems with which we deliver care have not kept up with the speed of science. This fact means our health system still struggles. We know we need to do better, right now, for our clinicians, our patients, and their families. So how do we get there? How, in such a complex industry, can we design systems that make it impossible for someone to make a wrong decision? How do we cultivate the attitudes of our leaders and staff so we support each other and the safety of our patients?

We will continue on the path to progress this year, step by step and idea by idea, and with the involvement of our frontline teams:

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- **We will innovate.** We will commission work teams of frontline staff, informatics, operations, executives, care providers, and others to take a hard look at improving and creating new processes for care delivery. We will use innovation and design thinking to ensure a broad and robust way of approaching problems and arriving at solutions. We will take our cues from the enormously successful problem-solving companies like IDEO, MAYA, and health centers such as Mayo Clinic Center for Innovation and Kaiser Permanente Garfield Innovation Center.
- **We will energize.** Our leaders will engage staff and learn about successes and concerns during rounding and management walk-rounds. Our staff members energize each other and our leaders by providing help when it is needed. They also demonstrate and engage in task assistance and mutual support, which are some of the foundational principles of ideal team performance. We are all on the same team, and we seek and offer help when and where it is needed. We will break down the barriers of "suits versus scrubs" and the energy-absorbing infighting and turf wars that result in poorly delivered care.
- **We will invest.** We invest in new technologies that will enhance care and ease the work flow burdens of our clinicians and supporting staff, all the while improving organizational productivity and performance. From electronic health records and fulfilling meaningful use of these technologies to computerized physician order entry, bar code medication administration, and smart pumps, we will ultimately improve patient safety and quality. Although the transition from paper and manual systems can be difficult and bring about new risks, we are confident that the end result is a safer system.
- **We will believe in our people.** Our care providers and those who support them are the heroes in all that we do. More often than not, our teams (clinical and administrative alike) intercept a mishap, an error, or a mistake before it ever reaches our patients. It is then that we can learn from these good catches and build safeguards in the system so that the mistakes do not happen again. We have faith in our teams to correct our system, make it better, and create healthier communities.

That is how we will design for safety. With our frontline staff, those who support them, our care providers, and our leaders, we are making this country's hospitals and clinics a safer place to be. This year, we will decrease our fall rates and medication events, our safety climate scores will improve, and we will work tirelessly to improve team performance and communication. As we continue through this next year, please help build a culture of learning, justice, and accountability for patient safety. For all that you do for each other, our patients, and their families, know that we are grateful. Happy New Year! ■

Questions of the month

Can you give us a review of current Universal Protocol?

Editor's note: **Patient Safety Monitor Journal** *provides expert answers to your patient safety questions.* ***Gayle Bielanski, RN, BS, CPHQ,*** *and* ***Laure L. Dudley, RN, MS, CSHA,*** *consultants with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, answer this month's queries. If you have a question for one of our experts, e-mail Managing Editor Tami Swartz at* tswartz@hcpro.com.

Q **Can you give an update on Universal Protocol™? What is currently expected of us?**

A The National Patient Safety Goal (NPSG) addressing the Universal Protocol has changed for 2010. The change is a simplification of the previous standard

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Questions of the month

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requirements. The objective of the Universal Protocol is to prevent wrong-site, wrong-procedure, and wrong-person surgery. There are three main aspects of this NPSG, including the pre-procedure verification process, marking the procedure site, and a timeout prior to the procedure.

The pre-procedure verification process must involve the patient to verify the correct site, patient, and procedure. A standardized list of documents, test results, and implants/blood/equipment required to be available for the procedure are available for the surgical team before the start of the procedure. This standard list does not have to be part of the medical record for each patient, but the majority of facilities do document such a list for each patient.

Marking the site of the incision or insertion is the second aspect of this NPSG. Site marking must occur prior to the start of the procedure and should include the patient when possible. The site marking needs to be done by the licensed independent practitioner performing the procedure. New for 2010, the requirement allows for a resident, advanced practice nurse, or physician assistant who will be present during the procedure to also be responsible for marking the surgical site. The designated marking must be consistent throughout the facility. A recent change is that the facility can determine what the marking type will be, such as the surgeon's initials or the words "yes" or "no," but the marking type must be used consistently throughout the organization. When a patient refuses to have a site marked, there needs to be an alternative process defined by the facility, such as using an eye patch or colored wristband.

The timeout process contains the most significant recent changes. Previously, there were nine elements required to be confirmed prior to the start of a procedure. Those requirements have been pared down to only three mandatory elements: verification of the correct site, correct patient, and correct procedure. This timeout must be documented, but the facility determines what the documentation includes.

Q We are trying to find a way to bring providers into compliance by providing a date and time with each order. The next challenge is with every entry in the patient chart. How can we ensure compliance in this area in a hospital that doesn't yet use computerized physician order entry (CPOE)?

A When the regulatory bodies speak of dating and timing entries in the medical record, they are speaking of more than just physician orders; they refer to all entries into the medical record. This includes documentation such as progress notes, clinical documentation, signatures on forms, and dietary consultations, to name a few. CPOE will only help with one aspect of medical entries. Hardwiring this requirement needs to be a complete culture change among all staff who make entries into the medical record, at least until there is a 100% electronic medical record.

Since this is probably one of the most frequently cited standards for noncompliance, it would be fair to say that few facilities have found a way to hardwire this into their institutions consistently. Some organizations have tried gadgets such as atomic pens, which staff can use to scan the date and time of posted entries. Other organizations have redesigned their forms to include a visual prompt for date and time.

Only by consistently monitoring and educating physicians and staff will any facility stay compliant until the electronic medical record is implemented.

Q How can we best standardize our handoff process?

A When The Joint Commission moved the issue of handoff communications from an NPSG into the

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standards (PC.02.02.01, EP 2) in 2010, it didn't become less important as an issue. On the contrary, it is recognized that the issue should be incorporated into everyday practice. Consider that communication issues account for an estimated 80% of medical errors. This emphasizes how important the issue continues to be in the complexity of the healthcare environment. The standard requires a key element: a process in place that allows an opportunity for questions between the giver and the receiver of information. Patient safety organizations are studying the best ways to accomplish a more successful handoff process that includes keeping the topic at the forefront of staff's minds to establish diligence and consistency in utilization.

Organizations tend to focus on the tools in their practice and their policies instead of the intent of what they are trying to accomplish. This sets up a series of complexities that may diminish what they are trying to do because it moves the focus off the process and onto the form. Whether using the SBAR or "I pass the baton" concepts, what organizations are really trying to convey is the importance of relaying critical information to the next level or provider of care. Consider starting out with the basics to establish your standard:

- What information is key to relay at a minimum in your organization? In other words, establish the content of what information is critical to pass along. This could include the patient's diagnosis, condition, treatment plan, and any recent treatments or anticipated condition changes.
- In what situations should this information be relayed? Examine your departments' services and review the types of information needed to be conveyed to appropriately reflect the patient's status.
- Determine the best way to relay the information. Once the basics are established, they can be customized to meet departmental issues. For example, the ED may want to fax the information to the unit receiving the patient, whereas the PACU may verbally relay it. Consider standardizing the process to improve compliance throughout the organization (although this is not currently mentioned in the standards). You can accomplish this by creating an internal tool or acronym such as DCTC (diagnosis, condition, treatment, changes) to highlight what is important. Then, if you decide to use a published tool, it becomes a support document as opposed to the main focus just to meet requirements. Successful handoff communication can only work when staff members are educated about its importance and are a part of the process to establish the standard.

Q Who completes medication reconciliation for surgical patients, the surgeon or the attending? Our surgeons state emphatically that they will not restart medications they did not prescribe. We can't seem to get the attending to consult quickly enough to reasonably say they should be restarting meds after surgery.

A The question really reflects the ordering of medications post-procedure. It would seem that the physician of record—or admitting physician—is ultimately responsible for the overall care of the patient regardless of how many consultants are involved. If the surgeon is the admitting physician of record, then he or she is responsible for determining the medications based on the patient's history and physical exam and not only on the issues related to the hernia or gallbladder being operated on. A patient's medication history is reviewed on admission, and there is documentation of current medications in the history and physical, which is completed prior to invasive procedures. That process alone should provide a level of comfort to the provider, who must write orders as to which medications the patient currently takes.

If this reluctance is pervasive, consider reviewing it with the medical executive committee, which oversees the bylaws and rules for acceptable physician practice in prescribing medications in your organization. ■

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