KNOCK OUT ERRORS THE SAFE WAY!

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BACKGROUND

Celebrating its 125th year of service, St. Joseph Medical Center (SJMC) remains committed to providing safe and effective care. Continuous national media coverage regarding safety issues has created a greater awareness among the public, patients, and their families nationwide. SJMC is located in Houston, Texas, and serves an urban population of approximately 1.5 million patients and their families.

To improve the level of care and reduce patient harm, SJMC has identified patient safety as a key priority and has implemented various initiatives to enhance patient safety outcomes.

STRATEGY/IMPLEMENTATION

Following a rigorous selection process, the Patient Safety Champions attended the first of many monthly meetings known as the “Breakfast of Champions” to review data, discuss initiatives and recognize and reward individuals leading the way in patient safety.

In addition to the monthly meetings, the Patient Safety Champions (PSC) conduct a fall huddle focusing on risk factors, risk-reducing practices, and best practices related to fall prevention.

PATIENT SAFETY CHAMPIONS

The Patient Safety Champions identify staff from their areas to represent the SMILE award.

The core values of SMILE are:

S – Speaks up for patient safety
M – Motivates others to deliver safe care
I – Illustrates safe practice habits
L – Leads the way in “doing the right thing”
E – Empowers staff to promote safe quality concerns

These key behaviors are essential for building an engaged culture of safety. Recipients of the SMILE award receive a gold coin, a gold key, and a picture posed in recognition of their activities.

HCAHPS IMPROVEMENT

Patient Safety Champions serve as a great resource and have expressed interest in working on many different aspects of both safety and quality initiatives. Having struggled organizationally with the HCAHPS indicator related to purpose and side effects of medications, our champions adopted the task of educating staff on what they can do to impact Communication regarding the effectiveness of medications.

ACTIONS:

PSC’s conducted a fall huddle on their units to determine the effect of improving patient care and causal factors contributing to medical errors. Initial data showed that many errors were preventable due to lack of adequate medication education, medication error reporting, and collaboration among staff.

In collaboration with Quality and Risk Management, PSC’s developed a medication error workflow on how and why they could improve results. Our Champions ensured scores were posted and discussed during monthly staff meetings.

CONCLUSIONS

Since its inception, the Patient Safety Champion program has produced measurable outcomes and enhanced the culture of safety. Though still a work in progress, during the first few months of data, we see positive trends in reporting of medication errors, increasing patient satisfaction scores, and a shift in staff awareness and ownership. Through auditing, education, and recognition, our Patient Safety Champions continue to target areas for improvement utilizing NDNQI benchmarking, HCAHPS measures and other safety tools. Our Champions have become well rounded bedside leaders who can see the impact of potential improvements on the spectrum of indicators.

REFERENCES


TOOLS OF THE TRADE

PSC’s have demonstrated initiative and drive to collect information and disseminate education to the unit populations. The tools (flyers, stickers, posters) are used to reach and provide messages to each of the team members with the expectation of immediate education on the unit. Targeted improvement initiatives are designed to monitor current trends in the data as well as safety and quality issues. Examples of the tools include: critical lab values stickers, post fall buddies, medication safety posters, HCAHPS, and other time-sensitive tools.

CONTACT

For further information regarding the Patient Safety Champions Initiative at St. Joseph Medical Center, please contact:

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STRESS AWARDS

The Mission of the Patient Safety Champion Program

St. Joseph Medical Center
Houston, Texas

RAISE AWARENESS AND INVOLVE COLLEAGUES IN WORKING TOGETHER TO IMPROVE PATIENT OUTCOMES AND ESTABLISH A CULTURE OF SAFETY WITHIN THE ORGANIZATION.

PURPOSE

The Role of the Patient Safety Champions –

• Serve as a resource for your unit/department regarding patient safety
• Survey staff safety behaviors
• Identify patient safety concerns
• Participate in patient safety PI activities

Present up to date information in monthly department staff meetings related to:

• PI team activities
• Policy/process revisions
• Best practices
• Trends in reported medical errors

Serve as liaison for staff questions/concerns

Observation audits

Identify candidates for SMILE awards

MEDICATION SAFETY

RATIONALE:

Reduction in Medication errors has been identified as a key priority for both safety and quality.

ACTIONS:

Reduce medication-related errors

Where We Are

2012 Total Reported Med Events

ANALYSIS:

Improved reporting resulted in identifying potential root causes of errors and process improvements.

Additional errors attributed to medication errors related to: process errors, order entry errors, and omitted information.

2012 Med Fall Rate Trending

FALL PREVENTION

Patient Safety Champions began working on fall prevention with a Medical Surgical and Surgical-Surg staff to develop a fall prevention plan. Both departments were combined into one service area.

The units were combined to include both surgical and medical surgical patients on one floor. These changes presented multiple challenges with the combined patient mix and provided ample opportunity for improvement.

ACTIONS:

Initiatives that our PSC’s assisted in implementing:

• Prevent falling data monthly to staff in order to increase awareness and empower them to have an active role in fall prevention

• Fall Prevention Policy was revised; added risk assessment procedures for the outpatient areas; expanded prevention strategies

• Expanded identification of patients at risk of falling with banding, yellow socks, and yellow falling star on patient’s door

• Expanded education to include inpatient, outpatient areas; expanded prevention strategies

• Updated guidelines for use of departmental gait belts with education provided by PSC’s

• Suggested bath mats to prevent falling in showers

• Suggested utilization of departmental gait belts with education provided by PSC’s

• Suggested bath mats to prevent falling in showers

• Communication RE: Medications

• Suggested utilization of departmental gait belts with education provided by PSC’s

CONCLUSIONS

Since its inception, the Patient Safety Champion program has produced measurable outcomes and enhanced the culture of safety. Though still a work in progress, during the first few months of data, we see positive trends in reporting of medication errors, increasing patient satisfaction scores, and a shift in staff awareness and ownership. Through auditing, education, and recognition, our Patient Safety Champions continue to target areas for improvement utilizing NDNQI benchmarking, HCAHPS measures and other safety tools. Our Champions have become well rounded bedside leaders who can see the impact of potential improvements on the spectrum of indicators.

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