TOPICS IN PATIENT SAFETY

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NCPS VA National Center for Patient Safety

Contents

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2006 Patient Safety Initiative

By Ellyn Wheeler, MHSA, NCPS program analyst and patient safety initiative project coordinator

In the summer of 2006, NCPS introduced the Patient Safety Initiative (PSI). The PSI is an opportunity for Patient Safety Managers (PSMs) across the VA to apply for funding for creative patient safety projects.

The goal of the PSI is to stimulate creative approaches to complex patient safety issues. PSMs are encouraged to develop and submit ideas for innovative patient safety enhancement projects for funding through NCPS.

When asked why she submitted a proposal to the PSI in 2006, one participant noted: "[We] felt it was an opportunity to have dollars available for a project that was deemed beneficial but for which local funding was not forthcoming."

A second applicant had been a member of a Failure Mode and Effects Analysis team that identified an action with huge potential to prevent harm, but there was no funding to take action. Funding received from NCPS through the PSI gave the facility the chance to explore whether the action could prevent a system break-down.

To apply for PSI funding, PSMs submitted a three-page proposal outlining their project idea. In 2006, NCPS received 49 individual proposals; 26 were funded.

Ginger Potts, PSM at John J. Pershing VAMC, Poplar Bluff, Mo., received funding from NCPS to procure "thin client medication units" on a trial basis for five beds on one of the medical center's acute care units. These units safely store medication and supplies; and, in conjunction with connected laptop computers, allow documentation and medication delivery to occur at the bedside. The goal of the initiative is to increase the amount of time the nursing staff spends with patients on medication administration, documentation, and monitoring activities, thereby enhancing the safety of those activities.

The effect of the thin medication units will be evaluated by calculating and trending fall and medication error data and patient satisfaction scores.

PSM Greg Wike, from the Central California Health Care System, submitted a proposal to purchase bright red, non-skid slipper socks for ambulatory, fall-risk inpatients.

The facility hopes the bright socks will make fall-risk patients more visible and decrease the chance they will be left to ambulate unattended. To measure the effect of the initiative, falls data will be collected. The facility will aim for a 20 percent reduction in both falls and injuries for the population wearing the new socks.

New York Harbor Healthcare System's PSM, Dea Hughes, is piloting a program to ensure wheelchairs are available and functional. Funded through the PSI, this wheelchair program will establish a multi-disciplinary group whose charge will be to determine the current status of wheelchairs, procure new chairs as necessary, and establish a process for monitoring and maintaining them.

Examples of other projects funded through the 2006 PSI include:

- Purchasing digital cameras to enhance wound care evaluation.
- Using clinical and research interventions to reduce hazardous wandering by dementia patients at home.
- Developing a suicide risk prevention tool kit.
- Reducing patient-to-patient infection transmission.

Results on outcomes of the funded PSI projects are currently being collected.

The 2006 PSI proposals were submitted on a variety of patient safety topics. The largest percent of funding dollars requested were for initiatives related to medication management and reconciliation.

Falls prevention initiatives, infection transmission and risk screening, and patient safety culture initiatives were other patient safety topics for which a significant percentage of total dollars were requested.

Continued on back page

How to Customize SBAR for Your Facility

By Debra Snyder-Rees, MS, patient safety manager; Charles C. Barbiere, RN, nurse supervisor; and Kathleen S. Shepard, RN, MSN, nurse educator

The VA Northern California Health Care System participated in Medical Team Training (MTT) presented by the NCPS on two occasions, June and August 2006.

A communication technique presented during the training, "Situation-Background-Assessment-Recommendation," commonly known as SBAR, was discussed at length and well received by our staff. In fact, facility leadership identified SBAR as a priority to help improve communication.

When our nurse executive team made a decision to implement SBAR and develop a related CPRS tool, an implementation team was formed. Each team member volunteered to develop one specific aspect of the plan.

Learning tools we decided to employ

- A seven-minute video about SBAR.
- A short slide presentation, to include CPRS documentation requirements.
- Role playing (showing both positive and negative approaches to SBAR).
- A pocket-size, laminated cognitive aide.
- A competency for SBAR techniques that would be required for all nursing staff.

Using the tools

The nurse educator presented nurse managers with the electronic documents that we planned to introduce into CPRS, as well as two options for training staff to use them to support SBAR:

- Ask staff to watch the video and review the slide presentation. Later, the nurse educator and manager would meet with staff to role play and complete the SBAR competency.
- Combine the above into one session — the video, the slides, role play, and competency.

The role play was very important, as it provided staff the opportunity to practice in a non-stressful setting. The educator used several methods, depending on how many people were in attendance and how much time was available.

These groups, primarily of three professionals, collectively worked through a number of aspects of SBAR implementation:

- Deciding what information to share with the physician.
- Deciding how best to arrange the information into the appropriate SBAR segment.
- Training staff to demonstrate the benefits of SBAR via role play.
- Deciding what to document; where to document.

Helpful Hints

Here are some helpful hints for other VA facility staff members who may want to develop this tool:

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SBAR Communication Tool

Assess the patient yourself.
        Review admit date, diagnosis, read recent MD and Nursing notes, current
        medications, IVs, allergies, labs, vital signs, and code status.

When calling MD/Nurse Expert/Nurse
(S) SITUATION
        Change in the patient's condition including date, time, symptoms
        Date and time physician's name that was called.
        What is the situation you are calling about?> Identify self, unit,
        patient, and room number. Briefly state the problem: What is it? When did
        it happen or start? How severe?
(B) BACKGROUND
        What is the patient's mental status? Describe his/her skin(warm, pale,
        moist, cold). What is the pulse Ox? Is the patient on O2?

(A) ASSESSMENT
        Tell the MD what you think the problem is (cardiac, respiratory, etc). Is
        the patient deteriorating? Is the patient getting worse? What do you
        think we need to do?

(R) RECOMMENDATIONS
        Suggest or request what you would like to see done:
                Orders received/actions taken.
                Transfer the patient to critical care, See the patient. Ask for a
                Consultant. Suggest tests needed (CXR, ABG, EKG, CBC).
                Suggest change in treatment.

(O) OUTCOME
                Results of orders/actions

After Calling the Physician/Nurse Expert/Nurse, or giving report.
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Since S-BAR is new to most staff, instructional prompts appear at the beginning of the note, but aren't displayed in the final one. We plan to remove the prompts after the staff becomes comfortable documenting S-BAR.

- Use the KISS method — Keep it simple!
- Remember adult learning principles (for a synopsis, see TIPS, March/April 2007: *www.patientsafety.gov/TIPS/tips.html*
- Use a variety of tools — for instance, as new articles appear in the current literature share them with staff.
- As always, be flexible and adaptable.
- Be willing to change the process as needed to fit your organization.
- Listen to frontline staff and follow up on their issues and concerns.

Lessons learned

- Ensure that policy matches practice (we revised a policy statement to match the actual practice of SBAR).
- Be sure you have a well-developed plan before implementing changes.
- Be willing to adapt and/or change to work through issues or concerns, regardless of the level of the staff member who makes a suggestion.

Summary

Making SBAR work takes time, patience and commitment, but it is well worth the effort!

As many of you learned through MTT, upon NCPS' review of 5,511 RCA case reports from VA Medical Centers throughout the United States, 78 percent of the cases identified communication failure as at least one root cause contributing factor in the reported adverse event or close call. SBAR is an outstanding way to meet this challenge.

Teams Honored for Patient Safety Design Initiatives

By Joe Murphy, APR, NCPS public affairs officer

Four teams were recognized for taking a creative approach to design during the VA National Patient Safety Managers Conference, held in Arlington, Va., March 2007.

VA patient safety professionals from around the nation had been invited to participate in the fiscal year 2006 Patient Safety Design Challenge, a voluntary program that allowed them the opportunity to have a positive impact on medical equipment and physical plant design.

"We were truly impressed by what the teams developed," said Joe DeRosier, program manager, VA National Center for Patient Safety, who led the Design Challenge. "This initiative fosters innovation at our facilities and is as an important new aspect of our patient safety efforts."

The National Center offered two categories: Architecture (design of medical care and treatment spaces) and equipment design. A business case analysis was also required for either design category submission, to include a cost benefit and cost effectiveness analysis.

The winner of the Challenge, the team from the Alexandria VAMC, Pineville, La., focused on lessons learned during Hurricane Katrina. A vertical evacuation device, the EvacuSled™, was modified by the team to facilitate patient evacuations.

The facility has five bed types, and staff found that the original model of the device was not compatible with all of them. The goal of the redesign was to make reasonable changes that would not alter special features of the bed's functioning or interfere with the safe deployment of the device.

"The most important thing for us was building a positive relationship with the vendors," said Myrtle Tate, VISN 16's patient safety officer. "Both vendors had to agree to modifications in design, a potentially costly investment. We convinced them of the importance of the project and that making the changes was the right thing to do."

Honorable mention was given to three teams.

The design for a state-of-the-art locked psychiatric unit, to be located at VAMC Coatesville, Pa., was submitted by the VISN 4 team, lead by Warren E. Medina-Riutort, RN, BSN, patient safety manager, VAMC Philadelphia. The project was selected because of the need for a safer and more secure environment for acute mentally ill veterans.

Patient Safety Manager Brenda Smith-McKenzie, RN, VAMC Gainesville, Fla., was team leader for a project that focused the design of the facility's new psychiatric unit. The current unit has a mix of patients, ranging from those diagnosed with schizophrenia to those suffering from substance abuse. The new unit is designed to separate these patients, thus improving patient safety and the quality of care.

At VAMC Tuscaloosa, Ala., a team led by Jannette Silvania, former facility patient safety coordinator, submitted design concepts to renovate bedroom and bathroom areas in the facility's psychiatric inpatient unit, centered on decreasing the risk of patient harm due to suicide gestures or attempts.

"The teams were very resourceful and inventive," said DeRosier. "We are looking forward to the 2008 Design Challenge and believe we will receive equally impressive entries."

The 2007 Design Challenge award is presented. (L to R): Joseph DeRosier, NCPS program manager; Mary Smith, patient safety manager, Alexandria VAMC; Myrtle Tate, patient safety officer, VISN 16; Barbara Watkins, director, Alexandria VAMC; Dr. James Bagian, VHA chief patient safety officer.

2006 Patient Safety Initiative *Continued from page 1*

Higher scores were awarded in 2006 for proposals that made a strong, specific argument for the utility of the initiative, given the amount of funding requested. Those that presented a solid (specific and feasible) strategy for measurement of outcomes were also given higher scores, as were those that possessed an element of novelty (a true initiative rather than an operational program). A clear explanation of how the initiative related to patient safety was also very important.

NCPS has allocated funds in 2007 to conduct a second year of the PSI. Application documents for next year's initiative will be posted on the NCPS Intranet site in early April. Final 2007 PSI proposals will be due in mid-May, and funding decisions will be announced by mid-June.

Funded 2006 PSI Funded Projects

Medication Management and Reconciliation
6 submitted, 2 funded

- Taking a JCAHO mandate to its full potential: pharmacist-led medication reconciliation. Linda Kraemer, VAMC Minneapolis, Minn.
- Nursing process redesign: a decentralized point of care approach. Ginger Potts, VAMC Pershing, Poplar Bluff, Mo.

Falls Prevention
10 submitted, 6 funded

- Prevention of falls in the home or outpatient setting. Susan Rude, VAMC Marion, Ill.
- Red socks for fall prevention. Greg Wike, Central California Health Care System, Fresno, Calif.
- Reducing unassisted bed and wheelchair exits that result in accidental falls. Randall Nentrup, VAMC Mt. Home, Tenn.
- Establishing a wheelchair procurement and maintenance program. Dea Hughes, VA N.Y. Harbor Health Care System.
- Proximity alarms. Janette Silvania, VAMC Tuscaloosa, Ala.
- Augusta VAMC "Falls Fair": Fall prevention and management program rollout. Julie Dangar, VAMC Augusta, Ga.

Infection Transmission and Risk Screening
4 submitted, 1 funded

- Patient-to-patient infection transmission. Helen Harte, VA Puget Sound Health Care System, Seattle, Wa.

Patient Safety Culture
5 submitted, 3 funded

- Patient safety education tool. Sandra Schlager, VAMC Marion, Ill.
- Development of a unit patient safety coordinator program. Alicia Shimabuku, VAMC Palo Alto, Calif.
- Electronic patient bulletin board. Sheree Keil, Amarillo VA Health Care System (Texas).

Lifting Injury Prevention
2 submitted, 1 funded

- Patient lifts proposal. Jane Wood, VAMC Canandaigua, N.Y.

Process for Baseline Counts of Adverse Events
1 submitted and funded

- The use of structured observation for stochastic modeling of risk in VA health care delivery. Thom John, Portland and Puget Sound, Wa., VAMCs.

Elopement/Wandering Prevention
2 submitted, 1 funded

- Safe wandering at home: clinical and research interventions to reduce hazardous wandering by persons with dementia. Dr. Helen Moore, James A. Haley VAMC, Tampa, Fla.

Pressure Ulcer Prevention
3 submitted, 2 funded

- Reducing dermal injuries related to pressure, shear, friction and moisture in the elderly at-risk veteran nursing home population. Randall Nentrup, VAMC Mt. Home, Tenn.
- Implementation of digital camera wound program. Margie Burch, VAMC Louisville, Ky.

Suicide Prevention
1 submitted and funded

- The development of a suicide risk prevention tool kit for health care providers. Terri Elsholz, Carl T. Hayden VAMC and Clinics, Phoenix, Ariz.

Electronic Incident Reporting
1 submitted and funded

- Improving patient safety via electronic incident reporting. Jacqueline R. White, Spark M. Matsunaga VA Medical and Regional Office Center, Honolulu, Hawaii.

Hand Hygiene
3 submitted and funded

- Hygiene utilizing VA-3M six sigma project guidelines. Jane Murphy, Richard L. Roudebush VAMC, Indianapolis, Ind.
- Patient hand hygiene. Darlene Brandeberry, New Mexico VA Health Care System, Albuquerque, N.M.
- "Gotcha' Award! Clean hand vs. dirty hand – doing the RIGHT THING for the RIGHT REASON." Elizabeth Walker, WJB Dorn VAMC, Columbia, S.C.

Vaccination
3 submitted, 2 funded

- A social marketing strategy to improve healthcare worker influenza vaccination rates. Cindy Berg, VAMC Tomah, Wis.
- Healthy Living Passport. Sheree Keil, Amarillo VA Healthcare System Amarillo (Texas).

MRI Safety
1 submitted and funded

- Designing and implementing a mock-up exercise to enhance patient, staff, and visitor safety in a new MRI suite. Jimmie G. Davis, VAMC Birmingham, Ala.

Other
3 submitted, 1 funded

- Hands-on training lab for medical residents from two training hospitals. Tony Lantzer, John Cochran VAMC St. Louis, Mo.