



# Briefings on Patient Safety

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## Summaries, outlines help patients understand safety information

The administration at St. Luke's Behavioral Health Center in Phoenix believes that informing patients is the best way to involve them in their care. That's why the hospital uses a patient handbook.

To make sure patients aren't overloaded with information, Patient Safety Officer and Director of Therapy Services **Jill Erickson, OTR-L**, put together a one-page summary that explains patient safety, the hospital and patient's role in safety, and ways to contact staff about patient safety concerns.

### NPSG 13A

The Joint Commission's National Patient Safety Goal (NPSG) requirement 13A asks hospitals to define the ways that patients and families can report concerns they have about patient safety. It also requires that hospitals

encourage patients to make those reports.

To meet the goal, the bulk of the St. Luke's patient handbook's patient safety section comprises areas of concern from The Joint Commission's Speak Up campaign. Other information includes sections about HIV/AIDS, oral hygiene, and Hepatitis B and C. The latter sections help the hospital meet regulations for behavioral healthcare facilities, says Erickson.

**See a sample patient safety summary on p. 3.**

"We have an opiate treatment program, and that requires giving patients information on HIV/AIDS," she says.

### Use summaries to introduce safety material

The section comes with an introduction that neatly outlines the hospital's position on patient safety and explains what information the patient can find in the handbook.

It also gives patients advice on keeping their care safe and offers instructions on who to contact with their concerns, as well as how to reach them. There are several of methods outlined, which makes it easier for patients to express their worries to the hospital staff.

### Use teamwork to build the best section possible

The section and introduction were designed by the hospital's patient safety team, which includes representatives from the different disciplines at the hospital, says Erickson.

"As we addressed the National Patient Safety Goals, we brainstormed different ways to meet [requirement 13A]," she says. "We thought that the handbook would be the perfect place for this information."

Once the Speak Up information and other sections were collected, Erickson wrote the introductory page.

> continued on p. 2



#### IN THIS ISSUE

**p. 4 Patient flow is patient safety**  
Patient flow remains a top hospital priority. Learn new ways to help improve your flow without adding a new wing to the hospital.

**p. 6 Goals reviewed**  
Joint Commission patient safety director Richard Croteau clarifies the finer points of the National Patient Safety Goals during a Joint-sponsored audioconference.

**p. 8 Star light, star upright**  
See how one hospital has used the Falling Stars program to decrease patient falls.

**p. 10 Better communication leads to safer care**  
Communication breakdowns are the most common reason for sentinel events. Using the two-challenge rule can help you avoid errors.

**p. 11 Staff Trainer**  
See how you do against our medication crossword.

## Safety info

< continued from p. 1

“We wrote it to sort of weave the patient into the process,” she says.

Once the section was written, it was approved by the patient safety, performance improvement, and operations teams, adds Erickson.

### Inform patients how to use handbook

Patients are given the handbook when they are admitted to St. Luke’s, and a staff member reviews its contents with them, says Erickson.

The handbook, including the patient safety section, is also reviewed during patient orientations. Patient stays

tend to be longer at behavioral hospitals than general care hospitals, which is why orientation sessions are held, she says.

“We found that the more patients know about their care and . . . what they have to do up front, the better it is for patient safety,” says Erickson.

### Get upper management support

Erickson says patient safety is a major concern of the upper management at Iasis Healthcare, which controls St. Luke’s.

That gives her a the freedom to

push new patient safety initiatives.


“It comes from the top down,” Erickson says. “If you don’t have organizational support, it makes things very difficult.” ■

**“We found that the more patients know about their care and . . . what they have to do up front, the better it is for patient safety.”**

—Jill Erickson, OTR-L

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Illustration by  
David Harbaugh



“Your fall team needs a lot of work.”

**Sample summary tool****Patient safety section****What is St. Luke's Behavioral Health Center (BHC) doing for patient safety?**

- St. Luke's has a specialized multidisciplinary team called the Patient Safety Team.
- This team works on implementing all of the National Patient Safety goals provided by accrediting body The Joint Commission. These goals are designed to prevent medical errors and to keep communication open and the environment free of hazards.
- St. Luke's has adopted the Speak Up program to get patients and families involved in patient safety.

**What can you do to help patient safety?**

- Ask questions of all caregivers
- Pay attention to the care you are receiving
- Educate yourself about your care and treatment
- Ask a family member or trusted friend to be your advocate
- Know your medications and why you take them
- Participate in decisions about your treatment

**In this section of your handbook you will find the following:**

- The Speak Up program:
  - "Help prevent errors in your care"
  - "Thing you can do to prevent medication mistakes" (English/Spanish)
  - "Planning your Recovery"
  - Hand hygiene
- Oral hygiene.
- Educational materials on HIV/AIDS, prevention of hepatitis B and C, and tuberculosis. Other educational information is available on request.

**Who can I contact if I have patient safety concerns?**

- You can share your concerns or suggestions with your nurse, the charge nurse, the nursing supervisor, or the director of inpatient services.
- You can contact the patient safety officer for St. Luke's.

The Leadership at St. Luke's BHC wants your participation in patient safety.

Please be an active part of our team. Together, we can maintain a safe and therapeutic environment.

Thank you,

St. Luke's Behavioral Health Center

1800 E. Van Buren

Phoenix, AZ 85006

Director of inpatient services 602/251-8261

Patient safety officer 602/251-8723

*Source: St. Luke's Behavioral Health Center, Phoenix. Reprinted with permission.*

## Efficiency, small changes improve patient flow

A recent survey conducted by the American College of Emergency Physicians (ACEP) and software company TeleTracking shows that 65% of respondents surveyed believe that patient flow is an extremely serious problem in their hospitals.

Nearly half (49%) rank patient flow as a “top three” management concern. Sixty percent of respondents report that flow problems lead to more ambulance diversions.

These results confirm what hospital officials have suspected for some time—patient flow has become a priority for upper management, which means hospital staff should expect to see changes intended to improve flow.

However, the way in which those changes will be implemented remains unknown. In the meantime, there are some actions that hospitals and hospital workers can take to help increase patient flow and keep patients safe.

Patient flow is a hospitalwide concern, and not just endemic to the ED, says ACEP President **Brian Keaton, MD, FACEP**. One reason for the increase in hospital visits and the need for hospitalization is the improvements in medicine that have occurred over the past 20 years, he says. “People are living longer. We can pull people through an emergency more [frequently] than we could 20 years ago, so they may have more medical problems than before.”

Further, patient flow becomes a patient safety issue when boarded patients experience a delay in their care. For example, boarding sick patients in hallways and waiting rooms causes infection control implications. And delays in imaging can keep critical knowledge out of the hands of caregivers.

“From a safety standpoint, my ED anticipates sick patients are waiting in my beds and not in my hallway and waiting room,” says Keaton. “[The ED] is doing double duty.”

### Find a feasible solution

“We have to look at potential solutions, and there are only a few,” says Keaton. “One is to have more doctors and nurses and beds, but that’s not economically feasible.

The second is to move people faster, and we are working on that. The third is to build more capacity.”

Although the third solution offered by Keaton—to increase capacity—would help increase flow, it’s too expensive and time-consuming to ease the current overcrowding problem.

“In manufacturing, if you reach 85% capacity, you build more capacity. We can’t do that in healthcare,” says Keaton.

That leaves improved efficiency as the most economically viable solution, he adds.

Many hospitals employ proven manufacturing processes for improving flow,

such as lean management and Six Sigma, whereas others take a more piecemeal approach.

“There is no magic bullet,” says Keaton.

However, bed tracking systems can be time-saving tools for hospitals, says Keaton. For example, TeleTracking offers a system for tracking bed openings, bed conditions (e.g., whether beds have been cleaned, etc.), and occupied beds that are likely to turn over.

“This is not just an issue of patient convenience. It’s not an issue of proper service. This is an issue of patient safety,” says TeleTracking President **Anthony Sanzo**. “The ED is no place for a patient who needs chronic care. The longer the patient is boarded in the ED, the more likely that patient is exposed to increased risk.”

Such software solutions can help hospitals increase efficiency, but they are not the solution in and of themselves, says Sanzo. Tracking tools help make staff aware of more beds than they ever could be before. But it’s up to the hospital to refine its processes to get patients into those beds.

“Technology is an enabling tool to assist a flow improvement program,” he says. “The average hospital has about 200–250 beds. It is impossible for anyone in

**“In manufacturing, if you reach 85% capacity, you build more capacity. We can’t do that in healthcare.”**

*—Brian Keaton, MD, FACEP*

the hospital to know the status of every bed at any point in time without technology.”

**Identify pain points**

“Clearly, you want to be efficient. If I can’t get people out my back door and into the hospital, it creates a bottleneck,” says Keaton.

He describes several such pain points in moving patients efficiently through the hospital. “There’s one line at the ambulance bay. These are patients who generally need immediate care,” Keaton says. “There’s a second line at the triage desk, and some of them are very sick, too. But they aren’t causing a backup. They are spending their time in the waiting room. The problem is sick people who come in through the ED but can’t be moved to the rest of the hospital.”

Hospitals may sometimes use surgical recovery beds for overflow patients, which then creates a bottleneck through the surgical unit. Elective procedures may become delayed or canceled because staff can’t guarantee they will have a bed for the patient when they finish in the OR. It’s a tactic that could help improve flow during a disaster or emergency, but does not lend well to permanent use.

Staff can be instrumental in moving patients through the continuum of care, Keaton says. “The first step is just awareness,” he says. “If you have a physician or nurse responsible for the operation of the department, make [him or her] aware of a problem. You can address that.”

**Consider methods to improve flow**

To ease ED bottlenecks, hospitals should reinvent how they board patients, Keaton says. By spreading the responsibility for boarded patients throughout the hospital, the ED can deliver emergency care faster to patients who need it.

“Twenty floors each with one extra patient each is probably a lot safer than an ED with 20 extra people,” says Keaton.

There are a number of alternatives to building a bigger hospital, Keaton says. For example, his hospital uses a “bed czar.” The czar keeps in contact with the hospital’s units to maintain constantly updated information about the space availability throughout the facility. He or she can then coordinate cleaning beds after a patient is discharged, check for a patient in line for a room in that unit, and transfer that patient to the newly cleaned room.

Another tactic is to designate discharge beds, or a discharge room. The space is used for patients who no longer need medical attention but have not yet been discharged. Using dedicated space for these patients frees up hospital rooms and medical devices for patients who need them.

There are advantages for those patients awaiting discharge as well.

For example, they can wait in an attractive room free of noisy monitoring systems. “This is a comfortable area where [patients] can wait for the appropriate staff to discharge them, and it frees up the hospital bed for a sick patient,” says Keaton. ■

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## The Joint Commission offers clarifications on goals

The Joint Commission has reported an overall increase in noncompliance with its National Patient Safety Goals (NPSG), but this phenomenon could be more a function of tougher surveyors than a slide in vigilance by hospitals, says **Richard Croteau, MD**, Joint Commission executive director for patient safety initiatives, who provided insight into meeting the 2007 goals during a January 23 audioconference hosted by Joint Commission Resources. Surveyors have become more experienced in inspecting hospitals for compliance, said Croteau. "It takes a while for surveyors to get up to speed."

### Patient identification

Croteau said hospitals have demonstrated a good handle on the requirement to use two patient identifiers. However, hospital staff have faced challenges in labeling blood samples in the presence of the patient, a requirement that extends to anyone who takes a sample.

### Prohibited abbreviations

"Abbreviations are still the most difficult to get consistent compliance," said Croteau.

Because of the lack of compliance, The Joint Commission has not expanded the list of prohibited abbreviations. But that's going to change in 2008, according to Croteau. For example, the commission is considering adding new elements to the visit, such as greater than (>) and less than (<) symbols, as well as any acronyms or abbreviations for drug names.

Hospitals that want to expand the list on their own are free to do so, but Croteau warned that The Joint Commission would hold those facilities to the higher standard.

The prohibited abbreviation list does not apply to pre-programmed menus in computerized physician order entry systems, but that may change as well.

### Critical test results

Hospitals also seemed to struggle with requirement 2C for reporting critical test results in a timely manner,

although Croteau said he was unsure of the reasons why. To comply with the requirement, the hospital is allowed to define what constitutes a critical test, a critical result, and the appropriate time frame for reporting.

"The only specific requirement is that somewhere in your performance improvement activities, you include something on critical test results," said Croteau. "You decide what the time frames are. You decide what test results are critical."

### Patient handoffs

The key to meeting the handoff requirement is standardization, Croteau said. The Joint Commission doesn't require any communication tool or prefer that any specific information be transmitted, but it does want hospitals to use whatever process they select consistently. Doing so sets the proper expectation for both the departing and arriving staff member, he added.

However, different disciplines or units within the hospital may use different methods for their handoffs. For example, a physician-to-physician handoff may be different than a nurse-to-nurse handoff, because the two disciplines require different information. But all physician-to-physician interactions must follow the same format. "For each of these types of handoff, you must have a standardized process for conducting that type of handoff," said Croteau.

### Drug concentrations

Most hospitals have successfully limited the number and types of drug concentrations, says Croteau. However, he cited one major exception: pediatrics.

The Joint Commission has worked with pediatric medical organizations and determined that limiting drug concentrations is the safest practice in the field, even though almost all pediatric units use scales to determine proper dosage and concentrations, said Croteau.

The Joint Commission will require pediatric and neonatal units to use limited concentrations, but has pushed

the deadline to the end of 2008. "We recognized it would be unsafe to transition quickly from one system to another," said Croteau.

### Look-alike/sound-alike drugs

The recent revisions to the official list of look-alike/sound-alike medications came after several drugs were taken off the market or had their names changed, said Croteau. Hospitals must still select 10 pairs from the official list and take steps to reduce the confusion that accompanies medications with similar names. "This is an international problem and is one that's a high priority with the World Health Organization," he added.

### Labeling medications

Requirement 3D on labeling medications on and off the sterile field has also caused some confusion in the field, even though The Joint Commission's standards include clear instructions, said Croteau. Standard MM.4.30 outlines what is required when labeling medications. In particular, in the procedural setting, hospital staff must indicate the name of the medication and its strength or concentration.

"The volume is something not needed on the label unless it's relevant," said Croteau. "The only exception is when the medication is drawn up and used immediately."

In this case, "immediately" means that the staff member draws and uses the medication in question with no other action taken between the two steps. "It's a matter of one at a time. You can't draw three medications and administer three medications and call that immediate," said Croteau.

Prelabeled empty syringes are not allowed, but preloaded, prelabeled syringes are, Croteau added.

### Hand hygiene

The compliance rate for hand hygiene is strong, but Croteau shared skepticism that the field has solved this persistent issue. "To be honest, I don't believe it's as good as it looks," he said. He encouraged hospitals to remain vigilant in their efforts to record and monitor proper handwashing and use of alcohol-based hand gels.

### Medication reconciliation

The Joint Commission has received more questions about NPSG 8, regarding medication reconciliation, than any other goal or standard in its history, Croteau said.

"We acknowledged that this would be a challenge by introducing it, in effect, a year early," he said. "We are now in 2007, and while organizations have made progress, it's still a challenge."

The goal was clarified for 2007 with a new sentence requiring that hospitals give the patient a reconciled list of medications during the discharge process. Croteau broke the process into the following four distinct steps:

- ▶ Gather as accurate a list of the patient's home medications as is possible. Keep that list for future reference.
- ▶ Compare that original list with new medications the patient takes during his or her hospitalization. Check for any problems (e.g., duplicative medications, omissions from the original list, possible negative interactions with existing medications, and any other prescribing errors). Then use the data to create a current list of medications.
- ▶ Continually update the current list throughout the patient's hospitalization.
- ▶ When the patient is ready for discharge, reconcile the medications one more time and then send that list to the patient and the receiving caregiver.

"We don't say who should do these things. You decide that," said Croteau. "Beyond the four steps I described, we don't go into details on how you accomplish this."

The process does not require documentation, but if your policy demands the use of a form, you will be surveyed on its proper use, said Croteau.

The Joint Commission is examining possible exceptions to the medication reconciliation process for emergency care, he said. At presstime, the commission had not made an announcement on those exceptions.

### Patient involvement

"Patients are safer to the degree they can be involved in their own care," said Croteau.

> *continued on p. 8*

## Goal clarification

< continued from p. 7

This includes patients' families, who often are intimately involved in the patient care. Croteau stressed that family involvement extends to whomever the patient wants included, and not just a spouse or parent.

## Suicide risk assessment

Croteau tried to clarify the rules governing when a suicide risk assessment is needed under NPSG requirement 15A. In essence, the patient's primary complaint must be the emotional or behavioral disorder, or the likely result of such a disorder.

The requirement also covers instances of substance abuse, which could be a sign of elevated suicide risk. Croteau offered other examples in which a screening would be required, including an obstetrics patient with a history of postpartum depression.

## Universal protocol

There has been an increase in the number of reported wrong site/wrong patient/wrong procedure errors, but that may not mean an increase in actual cases, according to Croteau.

"I don't believe more cases are happening, but we see an increase in reporting," he said.

Croteau stressed that these errors should never happen, because following the steps of the protocol should reveal any inconsistency. "The challenge is why aren't we doing what we should be doing?" he asked.

## Future goals

Croteau hinted at a couple of possible changes for the 2008 NPSGs. He said there was a "fairly high likelihood" of anticoagulant management making it onto the list next year. He also pointed to disruptive staff as another possible addition, as The Joint Commission considers disruptive staff to be a barrier to safer patient care.

## Big changes in the FAQs

The Joint Commission plans to release an update to its NPSG frequently asked questions (FAQ), which are posted to The Joint Commission Web site.

The update will contain "significant revisions" from previous versions, Croteau said. The new FAQ was not available as of presstime. ■

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## 'Falling Stars' prevent patient falls

National Patient Safety Goal requirement 9B calls for hospitals to implement a program to help reduce the number of falls and measure its effectiveness. Staff at the Integris Southwest Medical Center in Oklahoma City say "Falling Stars" help them comply with this goal.

**Lara Teague, RN**, administrative supervisor and president of the Clinical Practice Council (CPC) for the hospital, helped start the Falling Stars program in November 2006 after feeling pressure from her hospital's administration.

"Our fall rating system was dated," says Teague. "It was mandated from higher up that we needed to find a way to improve the safety of our patients and increase fall awareness. Instead of just documenting the risk,

there had to be a way for staff to easily identify a patient's fall risk."

## Developed by nurses

In June 2006, the administration challenged Teague and her staff to develop a better system for tracking and preventing patient falls. The CPC, a group of bedside nurses who successfully implement programs at the unit-based level, developed the Falling Star program.

"The term Falling Stars came from a nurse who had worked in California and she said [that facility] had a Falling Stars program for falls but we took that idea and developed what we would make that term mean," says Teague.

The program makes it easier for staff to tell at a glance whether a patient is a fall risk. This is accomplished through the strategic placement of inch-wide strips of card stock with cascading stars on them. For patients who are determined to be high fall risks, the stars are white with a red background, says Teague. For patients who are determined to be low fall risks, the stars are purple with a yellow background.

### How it works

Once a patient is deemed a high or low fall risk, the falling stars are placed in a few locations, says Teague. First, a magnet with falling stars is placed on the outside of the door frame to alert anyone walking by or entering the patient's room.

Second, if a patient is being transferred, a flip chart with similar falling stars in either high- or low-risk colors is attached to the IV pole. Staff can tell from any angle whether the patient is classified as high risk, low risk, or no risk (a neutral colored paper with no stars).

"Radiology has been really instrumental in that because their transporters have really taken it on," says Teague. "So when they go to pick a patient up they look at the door frame, see the patient is a high fall risk, and turn their little flip chart so that everyone in radiology can see at a glance that the patient is a high fall risk."

Third, all high-risk patients are automatically given red booties to wear upon admittance. Normal patient booties are brown and blue, so it is easy for staff to differentiate.

Finally, patients are given an armband that easily identifies them as a high or low fall risk. The clear armbands have a slot for a strip of a double sided cardstock—one side with the red background and white stars (for high risk) and one side for the yellow background and purple stars (for low risk). Those patients who are not a fall risk do not have to wear the armband. The armbands were added after the hospital's latest Joint Commission survey and instituted in January, says Teague.

Teague stresses that because most patients are really only transported to radiology, the flip charts have helped propel the Falling Star program.

"In radiology, they would have no idea what kind of patient it was if the patient was covered up and it was hard to see [his or her] booties or armband," says Teague.

The patients are assessed to be a high or low fall risk based on the Morse Fall Scale. The scale provides a quick way to tell whether a patient is a fall risk. Nurses rate the patients with a number value along six scales, such as whether the patient has a history of falling or needs an aid to help with

walking. If the sum of these values is between 25 and 50, the patient is a low fall risk. If the sum is greater than 50, the patient is a high fall risk. Anything

lower than 25 means the patient is not a fall risk.

"The Falling Star program didn't take the place of our numeric system, it just enhanced and worked with the Morse Fall Scale to help staff know what type of risk a patient is," says Teague.

**"The Falling Star program didn't take the place of our numeric system, it just enhanced and worked with the Morse Fall Scale to help staff know what type of risk a patient is."**

—Lara Teague, RN

### Moving the program forward

Teague and the Clinical Practice Council have publicized the program mainly through word of mouth and by doing a lot of walking rounds. They also sent out e-mails and put up fliers around the facility to alert staff.

"I actually go floor to floor and visit with all of the nurses and interact with all of the different departments," says Teague.

Because the program is fairly new, Teague and her colleagues have not performed any assessments, but will monitor the program's success to see whether the Falling Stars have helped lower the number of patient falls. She hopes to measure this within the first year of the program.

"I hope to show by next November how much we've decreased falls by making [fall risks] more visual," Teague says. "Falls have to be turned in as incidents so [they] will be easy to track." ■

## Communication the root cause of medical errors

What we have here is a failure to communicate.

“Nurses and, I think, doctors are reluctant to challenge each other,” says **Beth Kohsin, MS, RN, CPHQ**, a retired lieutenant colonel in the U.S. Air Force. “People do not feel they have the stature to be able to say, ‘Hang on a second, I’m really concerned about this.’ ”

The results can be disastrous. Kohsin points to data from The Joint Commission that found that between 1995 and 2004 communication problems were the leading root causes of the following:

- Sentinel events (75%)
- Delays in treatment (85%)
- Medication errors (nearly 65%)
- Perinatal deaths and injuries (more than 80%)
- Ventilator events (65%)
- Wrong-site surgery (nearly 80%)

During that same time period, communication only played a role in 5% of infection-associated events. But by 2005, communication jumped to the leading cause of infections, accounting for 75% of them, according to The Joint Commission.

Kohsin knows whereof she speaks. In 2001, she was

selected to work for the Air Force surgeon general to develop the Air Force Patient Safety Program. In that role, she worked with her Navy and Army counterparts to develop safety initiatives for the U.S. Department of Defense.

Before her recent retirement from active duty, she served in the Air Force for more than two decades as a nurse working in various clinical areas, primarily the intensive care unit (ICU).

### Two-challenge rule

“I grew up as an ICU nurse, and one of the things they instilled in us is that the doctor is depending on you,” she says. “You are with the patient for eight or 10 hours. You have to be the eyes and ears for that patient. You have to speak up for [him or her].”

When Kohsin first started teaching medical team management in the Air Force, she had to train staff in something called the two-challenge rule.

That rule requires that anyone, be it a nurse, technician, or doctor, speak up and tell the team if they think something’s gone awry. If no one heeds that first warning, the person must bring it up a second time, possibly rephrasing it.

“We did pretty well,” Kohsin says. “What we didn’t do was teach the people on the receiving end that you will stop and listen. We didn’t really teach them how to effectively listen.” One problem, she says, is the hierarchical structure of both the medical and the military professions.

### Lagging behind aviation industry

Kohsin says she doesn’t think communication is any more difficult in the healthcare industry than in other high-risk fields. “But, for some reason, we’ve been a little slower on the uptake,” she says.

She likens the current state of healthcare to the aviation industry in the 1970s, when communication problems and interpersonal relations hampered safety.

> *continued on p. 12*

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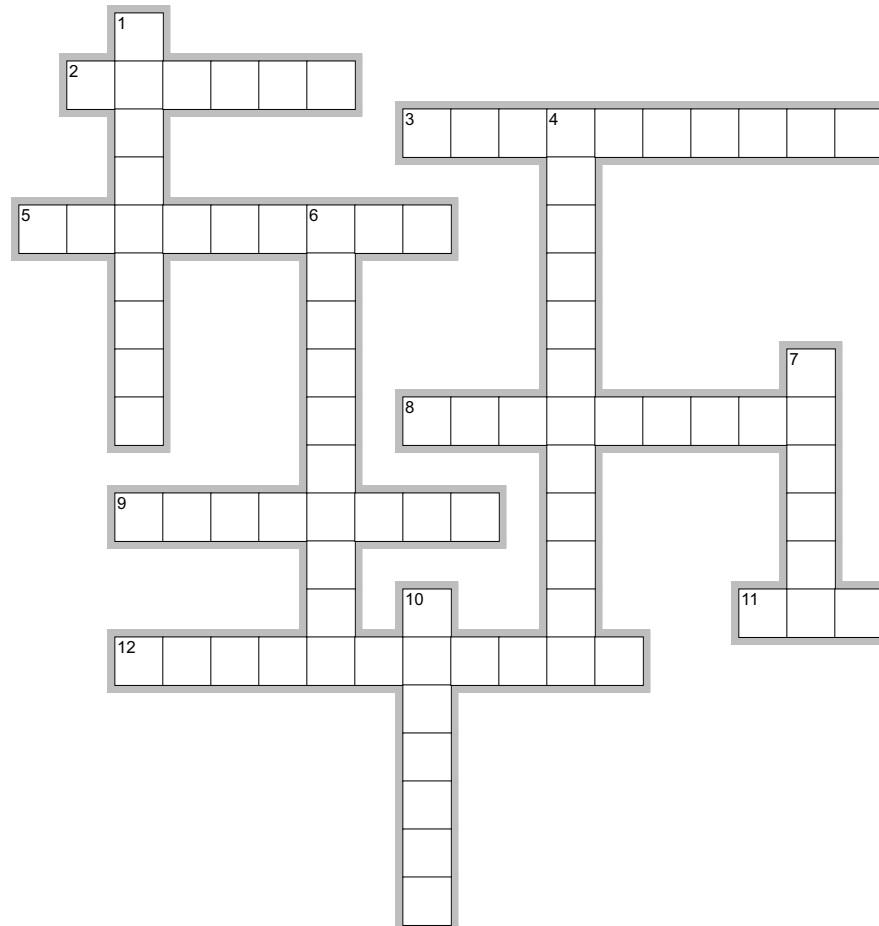
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## The BOPS Staff Trainer

### Medication crossword



#### Across

2. Amount of medication
3. One who is licensed to dispense medications
5. Something necessary and that should be documented for a medication to be ordered
8. What medication orders should not be, in terms of handwriting
9. The writing on a medication indicating what type of med it is and when it was first used
11. Three letter acronym for an event that happens when a patient doesn't respond well to a medication
12. Something that often needs to be monitored in the case of meds

#### Down

1. The name of one medication resembles another
4. Where meds often are kept to maintain a certain temperature
6. Medications that are pronounced similarly
7. Every patient has one that lists information about him or her, including what medications he or she is taking
10. One way of reconciling medication

## Communication

< continued from p. 10

"They started instituting the two-challenge rule and dynamic skepticism," she says.

If a mishap occurs, it's critical to step back and determine what caused it.

"It's not enough to say, 'Okay, we had this event,'" Kohsin says. "We have to say, 'Here's why we had it, and here are the factors leading up to that issue, and here's what we can do to fix it.' "

## Critical elements of safety

Kohsin cites the following three factors that are crucial to improving safety:

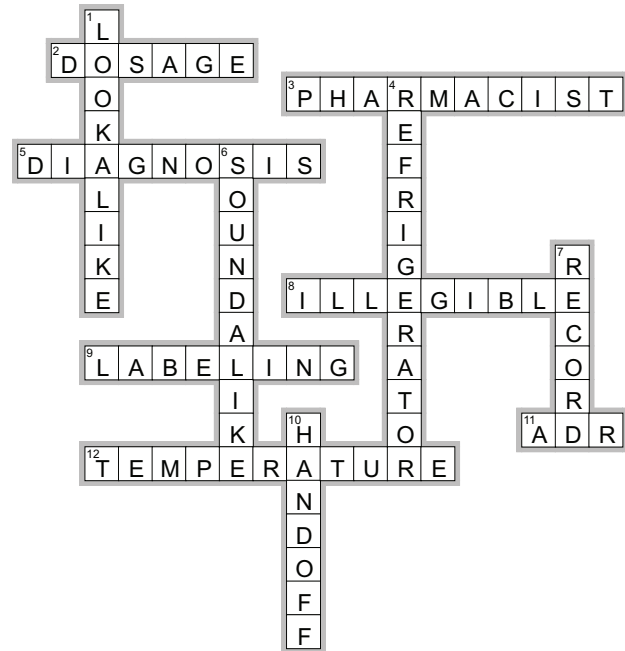
- **Strong leadership.** "Patient safety professionals need to help [leaders] understand this and show them the data from reported events. [CEOs] have to make a proclamation that 'We're going to take this on, and we're going to change it.' "
- **An action plan.** "I truly believe adopting a consistent method of communication, whether it be SBAR [Situation, Background, Assessment, Recommendation] or the four Ps [patient, progress, problem, plan], is probably a critical success factor. Not probably, it *is*," she says. "You need to be able to tap each other on the shoulder and tell a colleague, 'We're supposed to discuss this piece of critical information, and I didn't hear that.' "
- **Patient involvement.** "We're starting to get there, but we've got a long way to go," she says. "[Patients] are contributors, and we want them to contribute. No more, 'You're the doctor, I accept what you say . . . just tell me what to do.' "

Although Kohsin is disappointed that healthcare has yet to make the same safety gains as the aviation industry, she sees signs of hope. The IHI has inspired that optimism.

"I'm just very excited to hear [the IHI] say that perfect is possible," Kohsin says. "We can't accept the attitude anymore that some errors are inevitable. We need to throw down the gauntlet." ■



## Crossword answers



## Upcoming events

### Audioconferences:

**March 7**—Pain Management in Nursing: Incorporating evidence-based techniques in daily practice

**March 28**—Prevent Pressure Ulcers in your Hospital: Tools and advice from the field

**April 26**—Teaching patient safety to residents and faculty: Techniques and tools for training

*For more information or to register for any of our upcoming audioconferences, contact our Customer Service Department at 800/650-6787.*



