Quality and Safety Matters

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Asking People to Wash Hands

Empowering Patients to Protect Themselves

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Class of 2018

Sufficient hand washing is of paramount importance to patient safety—yet, even today, up to 50% of health care professionals fail to follow the proper guidelines [1]. However, there are simple changes that both hospitals and patients can implement to decrease this astronomical percentage, and improve patient safety.

Patients commonly feel as though they would be insulting the education and authority of their providers, if they were to question them about hand washing. However, patients DO have the right to approach medical personnel, especially when it pertains to their safety or health. How can we help our patients do this? We can teach them to say, "Can you please wash your hands, for my safety?" Evidence shows that rephrasing the request to include the patient's safety compels healthcare professionals to follow this procedure more closely.

A study at a North Carolina hospital, concluded that simply changing the phraseology of signs located at hand washing stations could positively improve rates of hand washing [2]. When formulated to address patient safety ("Hand Hygiene Prevents Patients from Catching Diseases") rather than personal safety ("Hand Hygiene Prevents You from Catching Diseases"), compliance rates notably increased. Simply changing one word can alter the mindset of staff, reminding them of the true importance of, and reason for, hand hygiene [2].

Just as patients need to be proactive members of their healthcare by asking professionals to wash their hands, nurses can do the same, asking for hand washing for the patient's safety when they see another professional is not following proper protocol to wash hands. By encouraging patients to speak up, and arming them with a phrase they can rehearse and use if needed, we help them protect their personal safety, as well as that of health care providers and other patients. Simple actions, such as informing patients of how to make a request to the health care provider, can make all the difference in the health and safety of patients.

1. De Wandel, D., Maes, L., Labeau, S., Vereecken, C., & Blot, S. (2010). Behavioral determinants of hand hygiene compliance in intensive care units. American Journal of Critical Care, 19(3); 230-239. Doi: 10.4037/ajcc2010892
2. O'Connor, A. (2011). Getting doctors to wash their hands. The New York Times. Retrieved from http://well.blogs.nytimes.com/2011/09/01/getting-doctors-to- wash-their-hands/?_r=2

Advocating for Patients

Communication Strategies to Facilitate Safety

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In May of 2012, *Today's Hospitalist*[1] published a story detailing the tragic death of a patient due to mere miscommunication amongst health care providers. A 37-year-old female was admitted to the ED at 9:00 pm with nausea, vomiting, and numbness. Her vital signs were assessed and she was ordered intravenous fluids. The nurse checked the patient's blood pressure later in the night and found it had increased, but did not report it. Later, when the patient's blood pressure continued to increase, the nurse reported it—incorrectly. Because of this communication error, no actions were taken to address the patient's condition. At 7:00 am, the patient was found lying on the floor. The patient was pronounced dead at 7:21 am of cardiac tamponade, caused by acute aortic dissection that had been developing over hours.

This is not an isolated incident. According to The Joint Commission[2] 80% of serious medical errors are due to miscommunications. Many solutions have been proposed to reconcile the miscommunication issue-patient safety briefings, daily patient goal sheets, and face to face nurse shift reports. However, the most promising of solution seems to be implementing SBAR.

SBAR is an acronym for Situation-Background-Assessment-Recommendation. This structured communication tool is used between health care providers. SBAR can be used in many clinical situations, such as conducting nurse-to-nurse shift reports. For example, the leaving nurse would report "Mr. Taylor in room 12 has just returned from an MRI (situation). He was admitted for severe abdominal pain (background). He just received pain medication and is reporting a pain level of 4 on a scale of 0-10 (assessment). He will need his vital signs checked and pain reassessed in 20 minutes (recommendation)." Patient hand-off, especially in the ED, can be chaotic, which makes a structured communication model vital; SBAR can help to prevent devastating communication errors.

SBAR improves the flow of information. When used as a consistently repeated pattern, errors become

Continued on page 2

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What Can You Do To Prevent Healthcare Errors?

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Patients are inadvertently harmed every day. Studies show that 1 in 3 Americans have or will experience a medical error at some point in their life in either their own or a family member's care.[1] How can we help prevent this?

The first step to prevent inadvertent harm to your patients is to acknowledge that harm may occur due to medical errors. When medical errors occur, often the "blame and shame" approach is taken in which individuals are singled out for their mistakes, but this approach fails to investigate the system problem that may have contributed. Most errors cannot be linked to one individual's actions but are a result of a flawed system that created the unsafe conditions. Safety is a team effort and requires the attention of all health care providers, working in partnership with patients and their families. Getting the whole health care organization on board to be committed to improvement can be challenging, but progress can be accomplished with commitment from individuals like you. Here are four specific behaviors you can do to improve safety:

Follow safety protocols. Protocols are everywhere in the health care setting. Whether it is hand washing procedures, specimen labeling and handling policies, equipment disinfection procedures, or pre-surgery checklists, these protocols are enacted to protect patients. It is your responsibility to follow the proper protocols to the best of your ability and to help others remember to follow them as well. Regardless of how well protocols and standards are developed, they only work if people actually follow them. In reality, not all protocols are equally effective. Speak up if a protocol is not working for you or your patients. Ignoring or not following a protocol is not the answer to improving patient safety. Be the first step in changing the system.

Speak up when you have concerns. Sometimes speaking up is hard to do, especially when it matters the most. But you cannot assume that someone else will speak up because the next person may think the same way. If something is being done that puts patient safety in jeopardy, speak up. If you see something, say something. Recognize that small errors can lead the way for big errors to follow. In addition to identifying and reporting issues with policies and procedures, take action by reporting unsafe working conditions or close calls.

Communicate clearly. According to the Joint Commission, approximately 80% of serious medical errors can be attributed to miscommunication between staff during hand-offs and transfers of patients.[2] Not only is effective communication between health care providers important, clear communication between you and your patient is crucial. Listen to your patients and their families. Take into account their culture, values and beliefs and encourage them to participate in their care.

Take care of yourself. Have you ever gone to work feeling sick or anxious about something, or running on minimal sleep? Most of us have at least a few times in our lives. When we are sick, exhausted, or stressed, we are not at our best and we put our patients are risk for harm. Being exhausted has been linked to having the same effects on cognitive performance as being intoxicated.[3] Additionally, unhealthy levels of stress have been linked to degraded performance. Often those who care for others, tend to care for themselves last. But it's important to remember that it is difficult to care for patients when you are not at your best. So care for yourself: try to get an appropriate amount of sleep and manage your stress and illnesses!

Integrating these four critical behaviors into your care can lead to better outcomes for patient safety. So are you committed to improving patient safety and reducing the risk of medical errors? Make changes today and lead the way for the rest of the health care team to get on board.

1.Kaiser Family Foundation / Agency for Healthcare Research and Quality / *Harvard School of Public Health National Survey on Consumers' Experiences with Patient Safety and Quality Information*, (November 2004). Retrieved from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/national-survey-on-consumers-experiences-with-patient-safety-and-quality-information-survey-summary-and-chartpack.pdf

2.The Joint Commission. (2012, June 12). Joint commission introduces new, customized tool to improve hand-off communications. Retrieved from website:http://www.jointcommission.org/issues/article.aspx?Article=RZlHoUK2oak83WO8RkCmZ9hVSIJT8ZbrI4NznZ1LEUk=

3. Rosekind MR, Gander PH, Gregory KB, et al. Managing fatigue in operational settings: An integrated approach. Hospital Topics 75. Summer 1997;31-35.

SBAR *continued from page 1*

more obvious. For instance, if a report fails to include the background information on a patient, SBAR will make that omission very clear. The receiver can then inquire about the patient's medical background so the best treatment can be provided. Furthermore, SBAR will help the reporter to remember the background information so the mistake is not made in the first place.

SBAR is a feasible solution for health care settings. Its implementation can be as simple as taping an SBAR sheet by the telephone or at patient bedsides. It can also be incorporated into evaluation forms and computer databases. As healthcare providers, we dedicate ourselves to improving patient care. SBAR is a technique we can utilize to further that mission.

1.Shepard, S. (2012, May 1). A fatal case of miscommunication. Retrieved from http://www.todayshospitalist.com /index.php?b=articles_read&cnt=1474

2. Joint Commission Center for Transforming Healthcare (2012) Targeted Solutions Tool for Hand-Off Communications. Retrieved from http://www.centerfortransforminghealthcare.org/tst.aspx .