

Safety*lutions*

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Partners in Patient Safety *promoting safety – minimizing risk*

The MMIC Group is pleased to announce that our Risk Management Department is enhancing its scope of services. As your partner in patient safety and risk management, you can expect us to provide innovative patient safety information as well as the acclaimed risk management services you have known in the past. Advice on implementing patient safety and quality initiatives, and practical steps to take – are just a phone call away.

MMIC has always recognized that promoting safe patient care goes hand-in-hand with minimizing your malpractice risk. You can anticipate enhanced patient safety information in our newsletters, publications and seminars.

The following resources are available for MMIC policyholders:

Safety*lutions*

A new risk management resource focused on patient safety. This newsletter adds practical insights on patient safety to the highly informative, helpful information you've received from us in the past. Look for a **Safety*lutions*** column in our newsletters – Perspectives on Prevention, and Partners in Prevention. **Safety*lutions*** educational programs, information and updates will also be available on the MMIC website.

Patient Safety Symposium

An annual education program focused on safety and held in regional locations. This symposium features experts who will discuss trends in patient safety. You also will receive practical information and tips that you can use every day to promote safe patient care and reduce malpractice risk.

Risk Management Services

• Education:

Physicians, allied health professionals, administrators, managers, patient safety officers and facility staff all have varied risk management and patient safety educational needs. MMIC will continue to offer the same quality educational programs in regional locations on a variety of risk management and patient safety topics.

• Self-Survey:

After completing a self-survey, your risk management consultant will contact you with suggestions to reduce your risk and improve patient safety.

• On-site Survey:

A focused survey can tackle high risk concerns identified by your:

- self-survey
- claim activity
- facility administrator, risk manager or patient safety officer

• MMIC Group Website:

On the website, you will find risk management:

- Publications
- Sample policies and procedures
- Lists of seminars and events
- Video library resources
- FAQs
- Links to websites for patient safety and risk management

• Consulting Services:

MMIC's experienced risk management staff provides education and consulting services to address the concerns of providers developing risk management and patient safety programs and policies. Staff advises on a variety of issues including patient safety, confidentiality, documentation, informed consent and handling patient complaints.

Consulting services include:

- Telephone or e-mail consultation
- On-site consultations
- Customized seminars
- Patient safety and quality initiative support

• Video Library:

As an MMIC policyholder, you can borrow videotapes from the risk management video library. Topics include patient relations, safety, avoiding medication

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errors and communication. A complete list of videos is available on our website.

MMIC is a partner in the Multilingual Health Resources eXchange, an online resource for multilingual health materials. As an MMIC policyholder, you have free access to a wide variety of health education materials in multiple languages via their website.

Information on the eXchange can be searched by topic, language or both and by keyword. Search results are available in print, audio or video formats.

To access the eXchange go to the website at: www.health-exchange.net

Click on the “Materials Index” icon and log in using these codes:

Log in name: mmic

Password: mmic

For questions about this site, contact Peggy Wagner, MMIC vice president of Risk Management at:

peggy.wagner@mmihc.com

Risk Management Publications

- **Risklutions:** Our common sense guide for clinics on promoting safety and minimizing risks
- **Perspectives in Prevention:** Newsletter for physicians and clinics
- **Partners in Prevention:** Newsletter for hospitals and facilities
- **Safetylutions:** Our newest publication focused on implementing safe practices that can help improve patient outcomes and reduce malpractice risk
- **Minimizing Obstetrical Risk:** Our manual for obstetricians and family physicians practicing OB
- **The Risk Management Handbook for Medical Office Staff:** This handbook familiarizes staff with key risk management and patient safety issues related to day-to-day clinic operations
- **Malpractice Handbook:** This handbook explains malpractice and provides a brief summary of the legal process of a malpractice lawsuit. It also provides risk management tips that, if implemented, can decrease the chances of a malpractice lawsuit. ●

www.mmigroup.com

Implementing a Patient Safety Program

Adverse healthcare events are becoming a leading cause of death and injury in this country. These largely preventable events can occur in any healthcare setting, in any community, in any place a provider sees a patient, including the physician office. Despite the heightened focus on medical errors and patient safety, many physician clinics have yet to develop a patient safety program. Many hospitals have implemented a patient safety program and now have a patient safety officer overseeing these efforts. Clinics need to become involved in patient safety efforts that are applicable to their setting to reduce the risk of harm to their patients.

The Agency for Healthcare Research and Quality (AHRQ) has identified 30 Safe Practices for Improving Patient Safety that can reduce or prevent adverse events and medical errors. The National Quality Forum, an organization representing 215 of the leading healthcare providers, purchasing and consumer organizations in America, has endorsed these safe practices. These evidence-based practices can be customized for any type of healthcare setting.

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Each of the 30 safe practices fits under one of the following categories:

1. Create a culture of safety

A safe culture promotes and supports the reporting of any situation or incident that threatens or could threaten the safety of a patient. In a safe culture, adverse events are viewed as opportunities for improvement, not instances for punishment. Personal accountability for quality patient care is emphasized and rewarded. Most efforts to improve patient safety will not be successful unless there is an organization-wide commitment to promote a culture of safety – from the board or administrative level all the way through every interaction with patients. The methods of fostering this environment may differ – but a safe culture is critical to the success of your patient safety program.

Suggestions for creating a culture of safety:

- Educate providers and staff about safe culture
- Use broad-based messages to inform all healthcare providers and personnel about the organization’s commitment to patient safety
- Include physician leaders and board members when broadcasting these messages
- Promote safe, non-punitive reporting of events
- Designate a patient safety officer to oversee patient safety initiatives
- Implement trigger tools to monitor adverse events

2. Match healthcare needs with service delivery capability

Evaluate the types of patients typically seen in your facility and have appropriately trained staff available. When adding new services (such as bariatric surgery or office-based surgery) use specialty society guidelines to select appropriate patients for the new service, provide education for all staff and follow published recommendations or criteria.

Fully inform patients of the risks and benefits of a proposed treatment including the benefits of seeking treatment at facilities that have demonstrated superior outcomes.

3. Facilitate information transfer and clear communication

Communication issues are the most frequent root cause in patient injuries and a frequent cause of malpractice claims. Effective communication is timely, accurate, complete and unambiguous – everyone understands the information, including the patient.

Patient Safety Tips

- Standardize abbreviations, acronyms and symbols
- Implement a ‘do not use’ list of dangerous abbreviations
- Use the “read back” technique to verify that telephone orders or critical lab results are communicated correctly
- Assess the timeliness of receipt and reporting of diagnostic and lab results

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- Use plain language (layman’s terms) with patients when discussing care and treatment
- Train providers and staff to use a communication tool such as SBAR (situation, background, assessment, recommendation) so that communication among the healthcare team is clear and efficient
- Ensure written documentation of patient preference for life-sustaining treatments is placed in the patient chart
- Implement protocols to prevent wrong-site, wrong-patient procedures

4. Adopt safe practices in specific clinical settings or specific processes of care

Individualize care to meet the needs of each patient. Implement safety measures to prevent common complications based on the patient’s diagnosis and treatment plan.

The 30 Safe Practices provide patient safety initiatives for patients at risk for:

- Acute MI during surgery
- Pressure ulcers
- Deep vein thrombosis
- Central line infections
- Surgical site infections
- Contrast media-induced renal failure
- Malnutrition
- Healthcare facility acquired infections

5. Increase medication safety

Medication errors injure at least 1.5 million people each year, according to the Institute of Medicine. The estimated cost of treating these injuries is \$3.5 billion per year.

Patient Safety Tips

- Use legible handwriting when prescribing
- Implement a “do not use” list of dangerous abbreviations
- Use electronic prescribing
- Standardize and limit drug concentrations
- Provide a clutter-free work area for medication preparation
- Monitor and document the use of sample medications
- Include indications for use when prescribing medication
- Prohibit “take as directed” instructions
- Keep a current medication list for each patient
- Encourage patients to participate in their medication management
- Identify high-alert medications, such as anticoagulants, insulin and narcotics with labeling to prevent dosage errors

Helpful Resources

Agency for Healthcare Quality and Research (AHRQ)

www.ahrq.gov

- 30 Safe Practices
- 10 Safety Tips for Hospitals

National Quality Forum (NQF)

www.qualityforum.org

- 28 Never Events
- 30 Safe Practices

Institute for Healthcare Improvement (IHI)

www.ihl.org

- 100,000 Lives Campaign
- 5 Million Lives Campaign
- Checklist for Hospital-wide safety
- Global Trigger Tools
- Information on developing a culture of safety

The Physician Practice Patient Safety Assessment

www.physiciansafetytool.org

Contact your risk management consultant for more information and for help implementing a patient safety program in your facility. ●

MALPRACTICE CLAIM REVIEW

Specialty:

Emergency Room

Allegation:

Incorrect Medication Administration

Risk Management

and Patient Safety Focus:

High-Alert Medication Errors

Facts of Case:

A 19-year-old woman came to the emergency room complaining of a rash that had started on her right thigh and had spread all over her body. She told the emergency room nurse that she'd had the rash for one week and it itched terribly. The emergency room physician examined her and ordered Solu-Medrol and Benadryl intravenous (IV), and subcutaneous (SQ) Epinephrine.

The nurse administered all three medications through the IV line. Shortly after getting the medications, the patient complained that she felt short of breath and nauseous. She was agitated, her blood pressure dropped very low and she began having red emesis. The emergency room physician ordered a chest X-ray that revealed non-cardiac pulmonary edema. He ordered nebulizer treatments and Reglan for nausea. Once stabilized, she was transferred to the intensive care unit.

The patient remained intubated and on a ventilator for 12 days. After her discharge from the hospital, she complained of frequent nightmares relating to her experience in intensive care. She saw a counselor and began taking Prozac and Ambien.

Disposition of Case:

The case settled for more than \$200,000 against the hospital.

Risk Management and Patient Safety Perspective:

The emergency room nurse stated she had never given SQ epinephrine and did not know that the emergency room stocked several different strengths of epinephrine or that proper administration of IV epinephrine required dilution. She testified that the order for IV and SQ medications was confusing and that she got mixed up because she had never given SQ epinephrine. She also admitted that following the patient's complications she changed her charting from the original Epi 0.3 mg given IVP to SQ by crossing out the IVP and writing in SQ.

IV epinephrine is a high-alert medication. The Institute for Safe Medication Practices (ISMP) defines high-alert medications as those drugs that bear a heightened risk of causing significant patient injury when they are used in error. ISMP provides a listing of high-alert medications on its website, www.ismp.org

Patient Safety Strategies to reduce medication errors involving high-alert medications include:

- Limit access to these medications
- Use auxiliary labels and automatic alerts
- Standardize ordering, preparation and administration
- Use double checks when necessary ●

Changes in Daylight Savings Time Can Affect Medical Devices

The adoption of the Energy Policy Act of 2005 changes the dates of daylight saving time (DST). DST will begin on the second Sunday in March and end the first Sunday in November. Some operating systems or platforms, including those in medical devices, will require patches or updates to handle this change. Contact the device manufacturer or your vendor for information on a patch to correct this potential issue. ●

Physician Practice Patient Safety Assessment Tool

The Medical Group Management Association for Research, the Health Research and Educational Trust and the Institute for Safe Medication Practices have created a safety assessment tool for physician practices. This tool will increase a practice's awareness of patient safety issues, heighten providers' awareness of characteristics that make a practice safer and create a new reference point and baseline for practices to enhance and support patient safety. The tool is available at:

www.physiciansafetytool.org ●

AHRQ Issues Patient Safety Tips for Hospitals

The Agency for Healthcare Research and Quality issued 10 patient safety tips for hospitals. The tips, gathered from study results, are simple and can be immediately put into practice. The list of safety tips can be found at: www.ahrq.gov/qual/10tips.htm ●

NQF Revises Reportable Event List

The National Quality Forum revised its list of serious reportable events by adding an additional event and materially changing six events from the initial list. These adverse events are serious, preventable and of concern to the public and healthcare providers. Information on the 28 serious reportable events is available at: www.qualityforum.org ●

Campaign for Writing End of Life Preferences

The American Hospital Association, with support from The American Society for Healthcare Risk Management, is promoting a national education campaign to encourage individuals of all ages to document their end-of-life preferences. The website has step-by-step instructions on how to complete advance directives, links to resources and a wallet card that can be downloaded to alert healthcare providers. The information is available at:

www.putitinwriting.org ●

AHRQ Issues Electronic Preventive Care Tool for Physicians

The Agency for Healthcare Research and Quality released a web-based tool that helps primary care physicians identify preventive care that might be appropriate for their patients. The Electronic Preventive Services Selector (ePSS) delivers the latest preventive care recommendations from the U.S. Preventive Services Task Force via a personal digital assistant or desktop computer. Physicians can input a patient's personal data and risk factors to generate a report. The tool is available at:

<http://epss.ahrq.gov/PDA/index.jsp> ●

Patient Safety News Video Update

The Food and Drug Administration has posted the latest edition of Patient Safety News, a web-based video news program for health professionals on its website. The video is available at:

www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/index.cfm ●

Wisconsin Requires Indication on Prescriptions

Last fall, a new state law went into effect in Wisconsin that requires prescribers, *when requested by patients*, to include the purpose of the medication on the prescription. For those prescriptions with an indication, the pharmacist will now print its intended purpose on the pharmacy-generated label. ●

IHI Announces 5 Million Lives Campaign

The Institute for Healthcare Improvement (IHI) recently launched the 5 Million Lives Campaign, a sequel to the 100,000 Lives Campaign. The goal is to enlist 4000 hospitals to adopt up to six new interventions, in addition to the six from the 100,000 Lives Campaign. All twelve interventions are aimed at reducing incidents of medical harm.

The six new interventions are:

- Prevent MRSA (Methicillin-resistant *Staphylococcus Aureus*) infections
- Reduce harm from high-alert medications
- Reduce surgical complications
- Prevent pressure ulcers
- Improve care for congestive heart failure
- Improve Board of Directors involvement in patient safety activities

The six goals from the 100,000 Lives Campaign are:

- Deploy rapid response teams
- Prevent adverse drug events
- Improve care for acute myocardial infarction
- Prevent surgical site infection
- Prevent central line infection
- Prevent ventilator-associated pneumonia

IHI estimates that there are between 40 and 50 incidents that cause harm to patients for every 100 admissions to a hospital, equating to about 15 million events in United States hospitals each year. IHI's goal is to eliminate one third of those over the next two years. According to Don Berwick, M.D., president and CEO of IHI, this achievement, if accomplished, will be the biggest improvement in patient safety in the history of modern healthcare.

As your partner in patient safety, MMIC Risk Management is available to assist you in your efforts to improve patient safety. Staff is available to discuss patient safety with your board of directors, medical staff or clinical staff. To let us know how we can best collaborate with you to promote safety and minimize risk in your organization please contact one of the following:

- **Nebraska and South Dakota:**
sheila.caffrey@mmihc.com
- **Iowa:** lori.atkinson@mmihc.com
- **Minnesota, Wisconsin and North Dakota:**
peggy.wagner@mmihc.com

The campaign materials and free how to guides are available at the IHI website www.IHI.org

Safetylutions 2007 Editorial Board

Editor-in-Chief
Cinda Velasco, R.N., J.D.
Attorney, Risk Management

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Manager, Risk Management

Lori Atkinson, R.N., B.S.N., CPHRM
Manager, Risk Management

Questions? Comments?

We're interested in your comments about *Safetylutions*. Call Sheila Caffrey, 800-328-5532 or fax (402) 397-3899 or e-mail Cinda Velasco, Attorney, Risk Management at Cinda.Velasco@mmihc.com

Articles in *Safetylutions* are not legal advice. Specific legal advice should be obtained from a qualified attorney when necessary.

The risk management recommendations contained in this newsletter are intended to be advisory only for MMIC policyholders. MMIC does not undertake hereby to establish any standards of medical practice. Although MMIC believes strongly in the effectiveness of good risk management, no guarantee can be made that claims experience will decrease if the recommendations are followed.

www.mmicgroup.com

Minneapolis Office

7650 Edinborough Way, Suite 400
Minneapolis, Minnesota 55435-5978
PH. (952) 838-6700 or 1-800-328-5532
Fax (952) 838-6808

West Des Moines Office

1415 28th Street, Suite 125
West Des Moines, Iowa 50266-1463
PH. 1-800-798-9870
Fax (515) 222-0966

Omaha Office

10330 Regency Parkway Drive, Suite 302
Omaha, Nebraska 68114-3736
PH. 1-888-397-3034
Fax (402) 397-3899