AUGUST 2021 VOL. 1

Alaska Native Medical Center
Patient Safety Quarterly

New Patient Safety Quarterly!

Welcome to the Patient Safety Quarterly, a new communication tool completely dedicated to patient safety! This communication is available to all staff by visiting the the Hub at anthcstaff.org!

ANTHC Behavior Expectations Spotlight: Communication

We respectfully and ethically interact with each other and those we serve and communicate to share information.
Listen to understand:

- The employee listens carefully, asks perceptive questions, and quickly comprehends new or highly complex matters.

When listening, the employee pays close attention, skillfully probing for clarification and additional information.

- Speak to inform
- The employee communicates clearly, concisely, and in meaningful ways without undefined acronyms. The employee is thorough and proactive about keeping others well informed.
- See a coworker exemplifying this behavior expectation? Submit a myHero rave in myHR!

Do you have a story or something to share in the quarterly? Contact the Patient Safety Committee at: patientsafetycommittee@anthc.org

In this Issue:

Patient Safety Tip: SBAR

SBAR is a communication tool used to communicate critical information that requires immediate attention and action concerning the patient's condition.

S: SITUATION
What is going on with the patient?

"Dr. X, patient in room 502-1 has alerted for sepsis at 0700."

B: BACKGROUND:
What is the clinical background or context?

"Their vital signs are BP 96/60, temperature 101.5 and lactate is 4."

A: ASSESSMENT
What do I think the problem is?

"This patient is SOB and has a productive cough. I believe they are exhibiting signs and symptoms of sepsis."

R:RECOMMENDATION and REQUEST
What would I do to correct it?

"I feel strongly the patient should be assessed now and we should initiate the Sepsis Powerplan."

Culture of Patient Safety Survey Results

Thank you for your participation with the 2020 Employee Engagement Survey! This three-part survey queries staff with questions focused on employee engagement, nurse satisfaction and culture of patient safety. In response to the culture of patient safety results, the Patient Safety Committee (PSC) has actively reviewed these findings and is focusing on promoting existing strengths and developing actions to improve the areas of concern.

In response to the Employee Engagement survey, one idea to improve communication between work units at ANMC was the creation of the Patient Safety Quarterly bulletin. Groups across campus are focusing on ensuring their work units are adequately staffed and job stress feels reasonable and manageable.

Current resources/tools that support communication between work units present at ANTHC:

- SBAR, a tool used to help facilitate communication (Situation, Background, Assessment, Recommendation)
- Behavior Expectations: a set of standards that staff have defined and are important for all staff to follow (communication, teamwork, quality, respect, accountability, and professionalism)
- Daily leadership safety huddles
- Safety share screen
- MediRegs/ANMC Policy & Procedure Portal
- ANTHC Today
- The Hub ANTHC staff news and event page and Hub recap twice-weekly newsletter
- ANTHC News Ambassador
- Data and Metrics
- myHero and staff recognition

Critical Stress Management (CISM) Team

The ANTHC CISM team is comprised of people specially trained in the International Critical Incident Stress Foundation evidence-based framework. All team members are ANTHC employees and report to a licensed behavioral health professional employed by the Behavioral Health Wellness Clinic. CISM team members follow a strict protocol to protect participant privacy and confidentiality.

To request CISM please email CISMTeam@anthc.org and provide:
1. Your name and department
2. Contact information (phone number, email address)
3. How we can help

A CISM coordinator will review your request and identify a CISM service that meets your needs. For requests received M-F between 8 a.m.- 4 p.m., we will contact you within two hours with next steps. For after-hours requests, we will contact you by 9 a.m. the next business day with next steps.

Root Cause Analysis

A Root Cause Analysis (RCA) is a tool used to identify key factors that led to an undesirable outcome. Completing an RCA helps improve care, safety, and outcomes for our patients. By completing an RCA we can build on or improve our current processes and safety systems. The goals when conducting an RCA is to find out what happened, why it happened and what can be done to prevent it from happening again. Staff members can share their input, concerns, and recommendations for improvement through the RCA process.

A recent RCA included a patient that was admitted due to fall with injury at home.
What: While admitted the patient had another fall while attempting to return to their bed after using the bathroom. This fall resulted in a mandible fracture that required surgical repair and postponed their discharge.
Why (root cause): The patient had cognitive decline. It was the first day for staff with this patient. The patient was left alone and asked to use the call light when she was done. The staff member assisting did not know the patient had cognitive decline and would likely forget to ask for help.
How: CNA report process was found to be inadequate in this case, as they are the ones responsible for making decisions (to stay or offer to leave for privacy). This decision is difficult with competing factors (tasks that need to be completed, other patients that need assistance). Staff assisting patients that are not their assigned patients and did not receive a report.

From this RCA and others like it, it is ANMC's aim is to reduce undesirable outcomes. ANMC has determined that processes with high amounts of variability increase the risk for errors or complications which can result in undesirable outcomes. We reduce these risks through standardization. Efforts to prevent errors like these include changes to procedures implemented for patients with a fall risk.

- Staff will remain within arm's reach of all patients who determined to be high fall risk.
- CNAs shared that it would be nice for this decision to be made for them, so they weren't constantly making this decision in the moment.
- Review our bedside shift report process so that it includes a CNA-RN report to ensure the CNA has the information needed to help in making important decisions, while also increasing the channels of communication between the health care team.

Previous changes to the falls procedure also came out of the lessons we learned from actual falls. Please reach out to Clinical Risk Management and let us know if you have any ideas or recommendations!

Sentinel Event Alert

Patient falls are consistently among the top 10 sentinel events. Since 2009,The Joint Commission reports 465 falls with injuries with 63% of those falls resulting in death. http://www.jointcommission.org/assets/1/18/SEA_55.pdf

How to Report Patient Safety Events

RL Datix Online

Available from The Hub under popular links – "Incident/Accident Reporting"
https://srm.rldatix.com/landing/ANMC

Should be used to report any patient safety event. Most events will be reported here.

Reporting Hotline

Call (907) 729-2329

Please make sure to include patient MRN, full name, location and all relevant details.

Should be used when reporting online is not possible.

Direct to Risk Management

- Any sentinel event
- Any serious patient harm event
- Any allegations of patient abuse or assault

Please Report in RLDatix as well as notify the Risk Manager on call via TT or email or through AOC.

Helpful Staff Resources

Leadership Safety Huddle

Who: Leaders from 34 departments across ANMC
When: Monday-Friday at 0845
What: Address safety issues from the last 24 hours or potential issues over the next 24 hours. Issues include staffing, supply issues, or inadequate processes.

Leaders will share pertinent information with their units. If interested, ask your leaders for weekly safety slides that are available every Friday.

ECRI: Patient Safety Organization

ECRI is an independent nonprofit organization improving the safety, quality and cost-effectiveness of care across all health care settings worldwide. ECRI utilizes an unbiased, evidence-based approach to develop guidance, and maintain principles of integrity and transparent work. ECRI is an online resource for any level of staff.
https://www.ecri.org/
Contact Coleen Fett, Director of Quality, for access.
Email: crfett@anthc.org
Phone: (907) 729-3937

Reports Portal

Reports Portal is a great place to find how ANMC is performing with patient safety measures.
The Reports Portal can be accessed via The Hub. You can find the following reports:

- ANMC Blood Utilization and Review
- Antimicrobial Stewardship
- Clinical Quality Measures
- Infection Control
- Inpatient Falls Dashboard
- Mislabeled Specimens

How can we help?

Each department can be reached through TigerConnect or by calling the operator.

Ethics & Compliance

- HIPAA/Privacy Concerns
- Monitor Health Records Access and Use
- Billing/Documentation Concerns
- Field Concerns Related to Employee Conduct
- Manages Policies and Procedures

Clinical Risk Management

- Patient Safety Concerns
- Investigate Events with Potential Harm
- Manage Incident Accident Reporting (RLDatix)
- Provide Support and Guidence in Complex Patient Issues

Corporate Risk Management

- Investigate Work-Related Injuries
- Ergonomic Assessments
- Provide Certificates of Insurance
- Approve Individuals to Drive on Behalf of ANMC

ANMC Safety

- Environmental and life safety concerns within patient care areas
- Radiation Dosimeters
- Hazardous Materials
- Waste Disposal
- Safety Data Sheets