

## QUALITY HEALTHCARE AND PATIENT SAFETY *Opposite Sides of the Same Coin*

Healthcare quality is measured as “the likelihood of desired health outcomes that are consistent with current professional knowledge.” For example, we know from large clinical trials that treatment of patients with congestive heart failure and systolic dysfunction with an ACE inhibitor will increase survival. Thus, a treatment program including an ACE inhibitor, (if not contraindicated) represents better quality healthcare than a program without ACE inhibitor. Translation of the findings from evidence based medicine into our daily practice increases the likelihood of desired outcomes for our patients and represents improvement in healthcare quality.

Safety is “the freedom from accidental injury”. Traditionally this has meant safety from fire, pestilence or act of God to whatever extent possible. More recently it has come to include freedom from medical error. It is this aspect of patient safety that is the opposite side of healthcare quality. Medical error comes in three varieties: failing to do the right thing (like using ACEI when indicated); doing the wrong thing (like administering the wrong drug); and doing the right thing in the wrong way (like giving the appropriate antibiotic, but 12 hours late). Patient safety is thus best ensured by the competent performance of qualified professionals working in effective and efficient systems. Team work is the essence of high quality, safe healthcare. Physicians, nurses, pharmacists, therapists, technicians, administrators, housekeepers, and support staff of all types all have critical contributions to make in the development and maintenance of effective and efficient systems.

*Core Measures* and *National Patient Safety Goals* make sense given this quality/safety duality. *Core Measures* are aspects of clinical practice that have been shown to increase the likelihood of desired patient outcomes like survival, functional status and satisfaction. While an individual physician may not see a dramatic difference in patient outcomes, this is usually a result of our one at a time approach to patient care. Larger studies do demonstrate an increased rate of desired outcomes. Currently we are involved in measuring and feeding back our performance in core measures involving acute myocardial infarction, congestive heart failure, community acquired pneumonia and pregnancy. We will be adding surgical infection prevention this spring. Individuals treating these groups of patients will see the data as we collect it. Starting this summer, the government will be posting core measure results aggregated by hospital on the CMS web site for the public to view.

(cont. page 2)

## CONFUSING COMMUNICATION - *A Common Pitfall*

Effective communication among members of the health care team is necessary to deliver the patient-focused care to which we all aspire. When critical information is not shared between physicians, nurses, therapists and technologists we set the stage for medical mishap. These lapses in communication are latent failures that expose well intended, competent and caring individuals to potential error. Fortunately for our patients, most of the time individual health care “heroes” recognize the potential for disaster and intervene to prevent actual error. They call or otherwise go out of the way to clarify lab results, vital signs, orders, allergies, drug lists, progress notes, patient requests, and family questions.

Communicating and processing information is a complex process that includes not only bites of data, but recognizable patterns of data and the relative priority of the data. All three elements need to be present for effective information transfer between individuals as illustrated in Figure 2. The more individuals involved in care, the more difficult this becomes.

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## QUALITY HEALTHCARE AND PATIENT SAFETY - *Opposite Sides of the Same Coin*

The *National Patient Safety Goals* have been developed based on consensus among safety experts and after review of the available data surrounding medical errors. The most common factors that contribute to medical errors are portrayed in Figure 1.

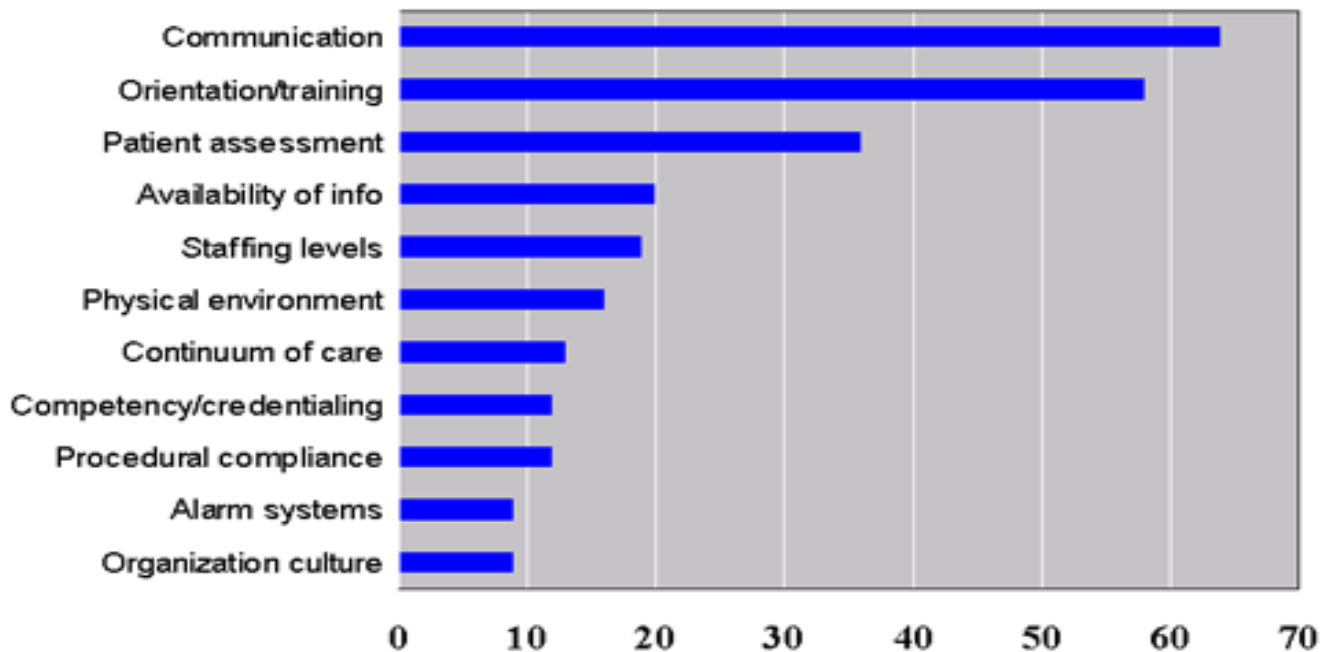


Figure 1

### The patient safety goals selected for 2004 are:

1. *Improve the accuracy of patient identification*
2. *Improve the effectiveness of communication among caregivers*
3. *Improve the safety of high alert medications*
4. *Eliminate wrong-site, wrong-patient, wrong-procedure surgery*
5. *Improve the safety of infusion pumps*
6. *Improve the effectiveness of clinical alarm systems*
7. *Reduce the risk of health care-acquired infections*

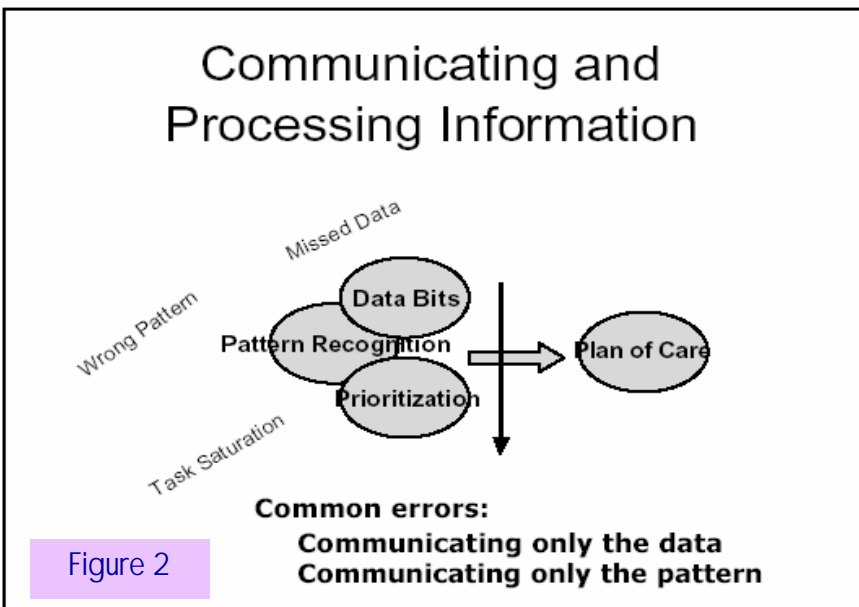
The Hospital Staff and the Medical Staff have been working together to improve our performance in each of these areas. Examples include the Physician Nurse Communication Taskforce (discussed in more detail elsewhere), avoidance of high risk abbreviations in the medical record, removal of concentrated electrolytes from the floors to the pharmacy, hand washing with alcohol-based products, upgrading clinical alarms, and the "time out" in the OR preoperatively.

Over time our safety goals will change to meet our changing needs. Significant strides have already been made in areas beyond the national goals, including the risk of patient falls and pressure sores. We all need to learn to recognize potential safety hazards and work together to correct the situations that expose patients, staff and visitors to the risk of harm.

## CONFUSING COMMUNICATION - A Common Pitfall *(cont. page 1)*

The Nurse Physician Communication Taskforce made four recommendations which have been implemented this past year, including:

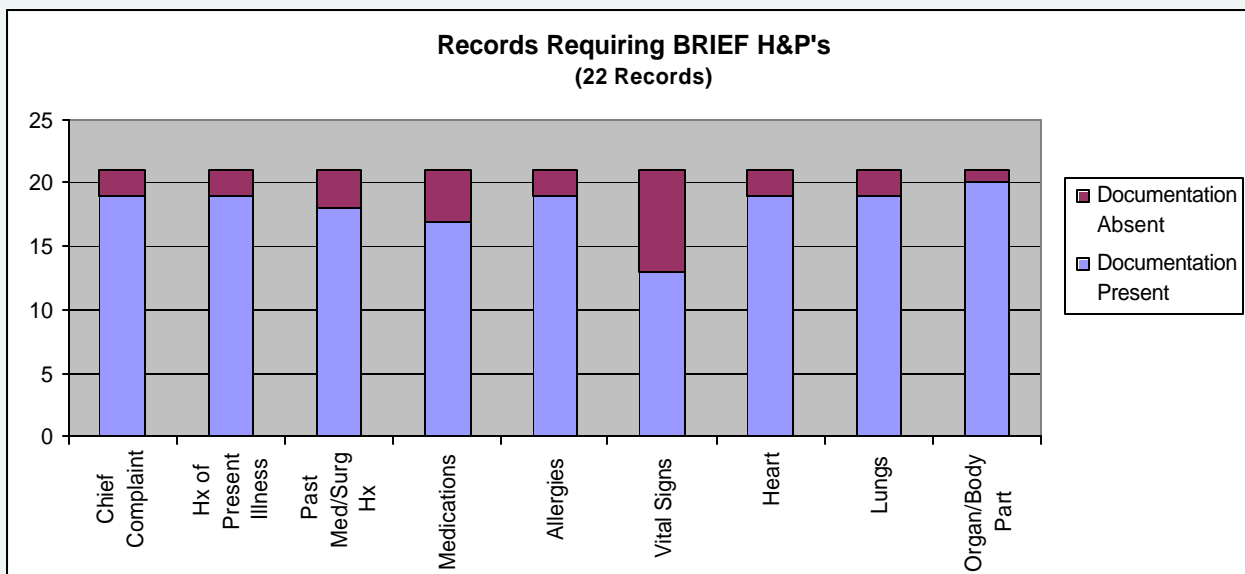
1. *Physician to physician contact at the time of consultation. A requirement for this has been included in our Rules and Regulations.*
2. *Development of a nursing competence on communication with physicians.*
3. *Read back of written verbal orders.*
4. *Use of a colored communication form on the physician progress notes for informal questions and answers that is not part of the permanent medical record.*



The chart is our primary tool for communication and to be effective it needs to be timely, complete and legible. The general expectation is performance at the level expected of us during our training. Specific requirements for the contents of a Brief H&P vs. a Complete H&P are contained in the Medical Staff Rules and Regulations. The results of a preliminary analysis of legibility and of the completeness of H&P's were presented at the December Medical Staff Meeting and are outlined below.

Type of Note	Partially Readable	Readable	Unreadable	Total
Nurses Notes	4.2	95.8	0.0	100.0
Physician's Progress Note	30.1	52.1	17.8	100.0
Physician's Orders	9.8	86.3	3.9	100.0
<b>Total</b>	<b>16.9</b>	<b>74.4</b>	<b>8.7</b>	<b>100.0</b>

Percentage of entries reviewed



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**A QUARTERLY  
NEWSLETTER PUBLISHED  
BY THE ST. JOSEPH  
HOSPITAL MEDICAL STAFF**

St. Joseph Hospital Medical Staff Newsletter is published by Medical Staff Affairs. Please submit ideas, comments, and suggestions to Dr. William Stephan, VP, Medical Affairs at 882-3000 extension 67046 or e-mail at: [wstephan@sjh-nh.org](mailto:wstephan@sjh-nh.org)  
Newsletter Designer: Sheila McLaughlin

**UPTODATE RESOURCE AVAILABLE**

A subscription-based clinical information resource, *UpToDate*, is available on any intranet terminal both for Medical Staff and Hospital staff. Topics include current information in most medical specialties.

If you need assistance with more complex searching, contact Cindy Sloan in the Health Science Library, at ext. 64301.

**Save the Date!**

**Quarterly Medical Staff Meeting  
Tuesday, June 15**

Dinner 5:45 p.m. (*SJH Cafeteria*)  
Meeting at 6:30 p.m. (*Carl Amelio Rm*)

**ADDING A NEW PARTNER?**  
*Start the Application Process Early!*

It generally takes about two to three months to credential a new physician and grant privileges. If you're adding a partner this summer, please make sure the new physician initiates an application for staff membership and privileges as soon as possible. Below are some frequently asked questions:

**1. Whom do I call for an application?**

Call St. Joseph Hospital Medical Staff Office at 595-5300 extension 63854 or 63811. At anytime, if a question arises while completing the application, applicants are encouraged to call for assistance.

**2. Why does the credentialing process take so long?**

JCAHO and Medicare standards require that hospitals obtain primary source verifications from all licensing and certification boards, post-graduate training programs, hospital affiliations, and peer references. Applicants can expedite the verification process by ensuring that their references respond to requests for verification and that their applications are complete.

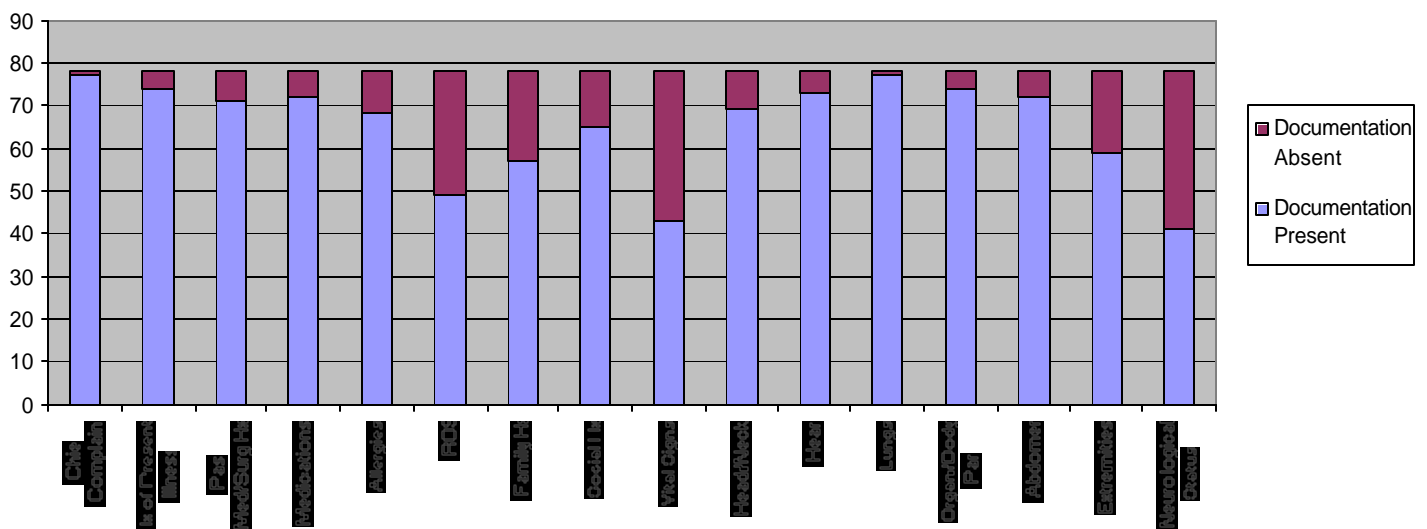
**3. What about temporary privileges?**

Temps are no longer an option due to compliance issues with JCAHO – only if there is a specific patient care need and for completed clean applications awaiting Medical Executive Committee. Please remember to get those applications started now, if possible!

If you have questions, contact Kathy Levesque or Robin Gurshick, Medical Staff Affairs, at 595-5300 ext 63854/63811 or via email at [klevesque@sjh-nh.org](mailto:klevesque@sjh-nh.org) or [rgurshick@sjh-nh.org](mailto:rgurshick@sjh-nh.org).

**CONFUSING COMMUNICATION** (cont. from page 3)

**Records Requiring COMPLETE H&P's  
(78 Records)**



A larger study is underway to allow review of several records for each provider. The results of this review will be available later this spring and will be provided to each participant. All too often we do not have a chance to step back from one patient at a time and look at our performance over several cases. This study will provide just such an opportunity.