Patient Safety Awareness Week Focuses on Patient Engagement and Safety Culture

The Institute for Healthcare Improvement (IHI) announced plans for this year’s Patient Safety Awareness Week, March 11-17, 2018. This year’s activities will focus on two critical issues—safety culture and patient engagement. This is the first Patient Safety Awareness Week since the National Patient Safety Foundation, lead sponsor of the event for 15 years, merged with IHI in 2017. The events planned promise to reflect the energy and commitment to safety and improvement of the combined organization.

Despite progress in patient safety over the years, studies suggest that medical error and preventable harm remain major sources of injury and death among patients. A recent national survey conducted by the IHI/NPSF Lucian Leape Institute and NORC at the University of Chicago found that 1 in 5 people reportedly experienced a medical error in their own care, and one-third reported an error in the care of a close relative or friend. Of those who experienced errors, 73 percent said the error had a long-term or permanent impact on the patient’s physical health, emotional health, financial well-being, or family relationships.

Nearly half of those who say they experienced a medical error spoke up about it to a medical professional or someone else on the staff of the facility where they received care. Of those who did not speak up, most said they did not think it would do any good, or they did not know how to report the error.

"Making sure patients and families feel that it’s okay to speak up and ask questions is really a critical element in patient safety," said Tejal K. Gandhi, MD, MPH, CPPS, Chief Clinical and Safety Officer, IHI. "Even health professionals sometimes fear speaking up, and that’s directly tied to the culture of the organization in which they work. In order to improve, health care organizations need to see flaws or gaps in safety, encourage people to report problems when they see them, and take action to correct them."


Did you know?
Every year, about 140,000 Americans are diagnosed with colorectal cancer, and more than 50,000 people die from it. Colorectal cancer is different than most cancers because it is largely PREVENTABLE and BEATABLE. When compared to other states, Nebraska has a much higher incidence and mortality rate for colorectal cancer so this is why it is so important to have proper colon cancer screenings. Help Saunders County improve our numbers by scheduling your colon cancer screening today! Dr. Rebecca Ehlers performs these screenings at SMC.
Infection Control Corner

Remember:
- Stay home if you are sick!
- Do NOT come to work if you have a fever!
- Wash your hands frequently!
- Cover your cough/sneeze using your elbow

Proper way to wear a mask

Nebraska Influenza Data

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of influenza test</td>
<td>30.83%</td>
</tr>
<tr>
<td>% of RSV rapid test</td>
<td>20.81%</td>
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<tr>
<td>Influenza-associated hospitalizations</td>
<td>398 inpatients</td>
</tr>
<tr>
<td>% of ED visits due to influenza</td>
<td>7.9%</td>
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<tr>
<td>% of school absence due to illness</td>
<td>3.36%</td>
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<tr>
<td>Number of influenza outbreaks reported</td>
<td>72</td>
</tr>
<tr>
<td>Influenza-associated mortality— all ages</td>
<td>56</td>
</tr>
<tr>
<td>Influenza-associated pediatric mortality</td>
<td>1</td>
</tr>
</tbody>
</table>

Synopsis for Week Ending February 24th, 2018

What is TeamSTEPPS?

TeamSTEPPS is an evidence-based set of teamwork tools, aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare professionals.

Communication Tools

SBAR: A technique for communicating critical information that requires immediate attention and action concerning a patient’s condition.

I am CONCERNED!
I am UNCOMFORTABLE!
This is a SAFETY ISSUE!
“Stop the Line”

CUS: Invoked when team members’ viewpoints don’t coincide with that of a decision maker.

A proper handoff includes the following components:
- Responsibility: Person is aware of assuming responsibility.
- Accountability: You are accountable until both parties are aware of the transfer.
- Uncertainty: Clear up all ambiguity before the transfer is complete.
- Communicate verbally.
- Acknowledged: Ensure that the handoff is understood and accepted.
- Opportunity: Evaluate the situation for both safety and quality.

Brief: Short session prior to start to share the plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, anticipate outcomes and likely contingencies.

Debrief: Informal information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positive behaviors.