

The Impact of Nurses: Improving Patient Safety





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Statistics substantiating a patient safety crisis in our delivery system

In 2000, the IOM published *To Err is Human: Building a Safer Health System* -- **26 years ago**

Experts estimated that as many as **98,000 people died** in any given year from medical errors that occur in hospitals. That's more than died from motor vehicle accidents, breast cancer, or AIDS--three causes that receive far more public attention. Indeed, more people die annually from **medication errors than from workplace injuries**. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems.



Statistics substantiating a patient safety crisis in our delivery system

More recent studies estimate:

- Between **200,000 and 400,000** patient deaths in the United States each year are attributable to preventable medical errors, making them the **third leading cause of death in the United States**. The financial burden is also substantial, with costs estimated at **\$20 billion to \$45 billion annually**, depending on whether hospital-acquired infections and their associated complications are included.
- Medical errors encompass a broad range of preventable events that occur throughout the continuum of care. Common categories include **medication, diagnostic, surgical, and procedural errors; healthcare-associated infections; communication or handoff failures; and patient falls**.



Statistics substantiating a patient safety crisis in our delivery system

According to the CDC and CMS:

- Patients with HAIs have historically required hospital stays averaging more than **four times longer** than uninfected patients (**21.6 days versus 4.9 days**).
- Hospitalizations involving HAIs generated **Medicare payments** more than **three times higher** than non-HAI admissions.
- Medicare payment estimates are approximately equivalent to:
 - ~\$**35,000–\$38,000** per hospitalization involving an HAI
 - ~\$**11,000–\$12,000** for comparable hospitalizations without an HAI

The Importance of Handwashing

Hungarian physician **Ignaz Semmelweis** is widely recognized as discovering the importance of handwashing in **1847**. Known as the "father of hand hygiene" he demonstrated that requiring doctors to disinfect their hands with chlorinated lime drastically reduced fatal infections in maternity wards.

Details of the Observation: In 1847, while working at the Vienna General Hospital, Semmelweis noticed that women in the first clinic (staffed by medical students) died of puerperal fever (childbed fever) at a much higher rate than those in the second clinic (staffed by midwives).

The "Cadaverous Particles": He realized that students and doctors would come directly from performing autopsies to delivering babies without washing their hands, transferring "cadaverous particles" to the mothers.

The Solution: He enforced a strict policy requiring staff to wash their hands in a chlorinated lime solution. As a result, the maternal **mortality rate dropped from 18% to less than 2%**.

Later in the 19th century his findings were further validated by the acceptance of germ theory, largely through the work of Louis Pasteur and Robert Koch.



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The beginning of my story



1991



Today



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Life Before and After Medical Error



Rory, Lisa and their 2 children



Rory doing Physical Therapy



Rory at home in his hospital bed



Rory – age 5



Rory at our daughter's graduation



Rory doing pool therapy



The Important Role of Nurses

- Healthcare is transforming
- **Care coordination** is now being highlighted as a key tool in improving patient health and safety.
- Nurses are well positioned to be natural advocates for patients . It is what many nurses do.
- What can YOU do to improve communication?



The Value of the Patient as a Partner

- The Patient and their family have been there the whole time and have the *whole story*.
- Informed Consent is a process, not a moment in time!
- There are often choices and those should be made with the patient.
- It is vital to improving patients' health outcomes.

What can happen when the patient's voice is not heard?



What can happen when the patient is not part of the care team?

- Critical information can be missed
- Outcomes that are not expected can occur
- Lives can be forever changed

REMEMBER: The patient is the only member of the team who has been there the whole time!



What happens to the patient experience when patients are actively engaged in their care?

- Critical information that only the patient knows is communicated
- Better results: the patient has a vested interest in their health because they are part of the care
- Higher Patient Satisfaction: we like to be people first and patients second
- Lower Health Care Costs: Less unnecessary procedures, better follow-up, less readmissions



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Patient- and Family-Centered Care: The MRI Challenge





What can you, as nurses, do

- Encourage your patients to be active members of their care team
- Make sure that they understand what they are being treated for
- Listen to them – really listen!
- Treat them as a person first – they are not a medical condition
- Protect them – wash you hands!



Grim statistics

- More than **one million medication errors** occur every year in U.S. hospitals. They are the most common cause of medical errors in hospitals, affecting 3.7% of patients. Fortunately, most do not result in serious patient harm.
- According to the 1999 Institute of Medicine report, *To Err is Human*, medication errors alone contribute to 7,000 deaths annually with medical errors accounting for 44,000-98,000 deaths each year! In 2013, John James published a study in the National Patient Safety Journal estimating that number at **over 400,000**. That makes **medical errors the third-leading cause of death in our country**.
- About **80 times each week**, U.S. patients undergoing surgery experience mistakes that safety advocates say should never happen: Mistakes such as wrong procedure, wrong site surgery and surgical instruments or sponges left in the surgical site – **NEVER EVENTS**.



Never Events

Appendix C. Connecticut Adverse Events in 2014			
Most Frequently Reported Events			
NQF List (1A-7D) and Connecticut-Specific List (CT1 & CT2)			
Event	Description	Frequency	Percent of All Events
4F	Unstageable, stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	245	52.0%
4E	Patient death or serious injury associated with a fall while being cared for in a healthcare facility	78	16.6%
CT1	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious disability	70	14.9%
1D	Retention of a foreign object in a patient after surgery or other procedure	24	5.1%
1A	Surgery performed on the wrong body part	15	3.2%
CT2	Death or serious injury associated with surgery	12	2.5%
All other reported adverse events		28	5.9%
Total		471	100.0%

From the October 2015 LEGISLATIVE REPORT TO THE GENERAL ASSEMBLY; Adverse Event Reporting General Statutes of Connecticut; Section 19a-127l-n; QUALITY IN HEALTH CARE PROGRAM



Never Events

Appendix C. Connecticut Adverse Events in 2023 Most Frequently Reported Events NQF List (1A-7D)

Event	Description	Frequency	Percent of All Events
NQF 4F	Any Stage 3, Stage 4, or unstageable pressure ulcer acquired after admission/ presentation to a healthcare setting	221	48.7%
NQF 4E	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	101	22.2%
NQF 5B	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances	33	7.3%
NQF 1D	Retention of a foreign object in a patient after surgery or other procedure	18	4.0%
NQF 3C	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	18	4.0%
NQF 1A	Surgery performed on the wrong site	12	2.6%
NQF 7C	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	11	2.4%
NQF 4A	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	10	2.2%
NQF 7D	Death or serious injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare setting	8	1.8%
NQF 1C	Wrong surgical procedure performed on a patient	4	0.9%
NQF 3A	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	4	0.9%
All other reported adverse events		14	3.1%
Total		454	100.0%

Communication and the Importance of Family Involvement

Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

*The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)*

2013 (N=887)		2014 (N=764)		2Q 2015 (N=474)	
Human Factors	635	Human Factors	547	Human Factors	464
Communication	563	Leadership	517	Leadership	382
Leadership	547	Communication	489	Communication	343
Assessment	505	Assessment	392	Assessment	247
Information Management	155	Physical Environment	115	Physical Environment	88
Physical Environment	138	Information Management	72	Health Information Technology-related	74
Care Planning	103	Care Planning	72	Care Planning	64
Continuum of Care	97	Health Information Technology-related	59	Information Management	29
Medication Use	77	Operative Care	58	Medication Use	29
Operative Care	76	Continuum of Care	57	Performance Improvement	26

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.



Office of Quality and
Patient Safety - 8

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Joint Commission Root Causes and Percentages for Sentinel Events (All Categories) 2013 - 2015



The Connecticut Center for Patient Safety works to

Promote patient safety

Improve the quality of health care &

Protect the rights of patients.



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Our Journey

- 2002 Medical liability battle In Connecticut
- 2005 Formed our own not for profit
- Legislation
- Media
- Education
- National and local voice for the patient experience



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We are grounded in stories

Medical error can have devastating effects. On our website, in their own words, families tell the stories of how medical error changed their lives ---
---forever.

Jennifer Manganello , Katie Tyra, Sydney Reich, Peter Ladd, T. Stewart Hamilton M.D., Michael, Katty Chavarria, Marcelle Franchino' husband, Felecia Gerardi, Matthew Gersz, Kate Govoni, Britt Harwe, Marilyn Jasmin, Rory Freeman, Peggy Lillis, Timothy Kertanis, Rudy Passero, Lorraine J. Piurowski's husband, Gus Velez and many, too many more.....



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The Gus Velez Story



Gus Velez
President Connecticut Patients Right Group



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Take-aways

- Communication - Teach Back





Take-aways

- Communication
 - Teach back
- Transitions
 - Documentation and Communication
 - Have patients record instructions on smart phones
- Patients are people first, not conditions
- Patients are the key to continuity
- Listen to your patients. They are the most underutilized resource in healthcare
- WASH your hands
 - Not all germs are killed with alcohol





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People will forget what you
said, they will forget what you
did, but they will never forget
how you made them feel!

~Maya Angelou



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Let us hear from you



Lisa Freeman,

lisa.freeman@ctcps.org



www.ctcps.org

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- Sign up for our newsletter
- Share your stories with us! Let them be learning moments!
- **VOLUNTEER** with us!