Quality and Safety Matters

TCNJ Nursing's Quality and Safety Newsletter

Volume 5, Issue 1 **October 2019**

20 Years Since *To Err is Human* Published

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In November of 1999, the Institute of Medicine published *To Err is Human: Building a Safer Health System*.[1] This report jump-started the patient safety movement in the United States, highlighting important factors in patient safety: preventing medical errors, disclosure of medical errors, enhancing knowledge about patient safety, and formation of safety teams within hospitals. Today, disclosure of errors is more commonplace, but 20 years ago, it was a new and challenging idea. Dr. Tejal Gandhi, Chief Clinical and Safety Officer for the Institute of Healthcare Improvement (IHI) recently was interviewed about the impact *To Err is Human* has had on healthcare today.[2]

Gandhi was asked to respond to a 2016 study at Johns Hopkins, which claims to have found that the third leading cause of death in America is medical error[3]. Gandhi noted that whether or not the findings are accurate, the ranking is irrelevant because nobody should lose his or her life due to medical error. She spoke about how people trust their doctors and nurses to take care of them and protect them and that when people die because of healthcare errors, it is a sign that the system is broken and more work needs to be done.

Gandhi focused on maternal and newborn health and safety stating that maternal deaths during and after delivery are entirely preventable but continue to occur. The United States has the highest rate for maternal deaths in the developed world and somehow, as the mortality rates decline in many places across the globe, they are increasing in America.[4] Additionally, this is an area of healthcare where there are significant disparities of care for women of color and other minority populations, blemishing a time that is intended to be joyful and exciting.

A large focus of improving patient quality and safety in recent years is related to the idea of interdisciplinary team training. Even though the jobs of nurses, pharmacists, doctors, techs, and therapists are different, they all have the same goal of patient healing and care. It is crucial for these areas of health care to be brought together in an organized fashion in order to accomplish the goals the original report pointed healthcare to work toward. Gandhi believes that it would be a good idea for different

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Medication Reconciliation for Every Patient

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The first questions that can come to mind when we hear the term, Medication Reconciliation is "What is it?" "What does it mean?" As nursing students, we hear this term in class and clinical but may not be so familiar with what it is until we truly learn about it and see it first-hand. This column will thoroughly explain medication reconciliation to make sure everyone knows why Medication Reconciliation is so important by the next time you go to clinical!

Medication Reconciliation is the process of reviewing all of the medications our patients are taking during their hospital stay, and comparing that list to their usual medication regimen. This allows us as health care providers, to formulate the most accurate list of medications that will benefit our patient's well-being while protecting them from harmful drug interactions. Without this, we could miss a dangerous medication mixture or potentially omit a medication that may have been prescribed at home or at the time of admission, transfer, or discharge from another facility. The review includes all prescribed medications, vitamins, herbal supplements, and over-the-counter drugs.[1] This is an important discussion to have with patients in order to keep them safe; by doing this, nurses help patients avoid medication errors such as duplications, omissions, wrong dosage of a med, and dangerous drug interactions.[1]

There are 5 steps that help us to complete a thorough medication reconciliation: 1) develop a list of current medication; 2) develop a list of medications to be prescribed; 3) compare the medications on the two lists; 4) make clinical decisions based on the comparison; and 5) communicate the new list to appropriate caregivers and most importantly to the patient.[1] As nursing students we can begin developing this skill during our clinical experience. By thoroughly examining our patients' medications, we will always be sure of their correct regimen when giving medications.

Other factors can create the need for Medication Reconciliation such as patients' lack of knowledge about their current medications, physician and nurse workflows (documentation style), and the lack of patient's health records being integrated across the continuum of care from another facility.[1] A lot of patients may not be familiar with what medications they are prescribed, and what each does; therefore, patient education is needed during this time as well. When it comes to documentation of physicians and nurses, at times medications can be written in different places such as the EHR or paper chart; creating the possibility of drugs being accidentally omitted from the patient's medication administration record. All of these factors can lead to another facility not receiving an accurate medication list if their new patient is a patient transferred from your facility.

Hopefully, this helps to create a better understanding of how important Medication Reconciliation with our patients is. It not only educates us to ensure we are knowledgeable of our patients' needs; it also creates the opportunity to educate our patients. Patient education is essential in health care in order to keep patients safe; knowledge for everyone on the team, including the patient is the basis of developing the best possible plan of care for our patients.

1. Barnsteiner, J. H. (2008). Patient safety and quality: An evidence-based handbook for nurses. Agency for Healthcare Research and Quality: Rockville, MD. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2648/

The Quadruple Aim in Healthcare

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It takes a motivated person to work in healthcare. Healthcare workers have the incredible opportunity to encounter patients across the lifespan, helping them through the challenging and life-altering situations that they experience. This task is truly a gift, but why are so many healthcare workers reporting a decreased happiness in their profession? This concerning finding is the focus of Don Berwick and his colleagues at the Institution for Healthcare Improvement (IHI).

Berwick has supported the Triple Aim for performance reformation in the healthcare industry.[1] The Triple Aim provides a framework for healthcare institutions to work toward improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care. Although these are great goals to aspire towards, many practitioners have expressed that the stress filled working environment has continually made it harder to achieve these aspirations. Bodenheimer and Sinsky wondered if a fourth aim needed to be added to the plan in order to positively impact the way healthcare is provided.[2]

Patients rightfully have expectations when entering the health care system. They expect improved health conditions, decreased wait times, and increased patient-provider relationships, but resources are simply not abundant enough to make these expectations a reality for all patients.[2] The disparity between these requests and actual resources leads to worker burnout. Healthcare employees continually feel like their efforts simply don't measure up, being pulled in so many different directions.

A study of physicians indicated that the electronic health record (EHR) has led to a decreased satisfaction in the workplace.[2] Physicians expressed that time that could be spent with patients is instead spent charting and typing write ups on their visits. Although technology has transformed the healthcare system to what it is today, there are still technology issues that inhibit work satisfaction.

Although the Triple Aim for healthcare is a great starting point to get healthcare associates thinking about reform and improvement, a fourth aspect of increased worker satisfaction-namely joy, is essential. No person can properly care for another if his or her own physical and mental well-being is diminished because the work environment is difficult. Whether it is through initiatives such as implementing team documentation, including pre-appointment lab testing, expanding the roles of assistive staff, or constructing community work environments, the Quadruple Aim goal is plausible for the future, attainable, and truly has the potential to change lives of employees and patients worldwide.

1. Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Aff (Millwood). 2008;27(3):759–769.
2. Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine, 12(6), 573-576

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disciplinarians to "walk in others' shoes for a day". When this happens, there is a better understanding of the value of each component of the team and communication between team members is enhanced. All team members should be trained to work together, Gandhi postulates, so that there is enhanced care.[2] Doctors cannot work without nurses. Nurses cannot practice without doctors. Nurses cannot effectively care for patients without care techs. Each role is incredibly important in creating an efficient and effective team with the priority of caring for patients.

People working in healthcare are an essential part of society. They spend their lives trying to help others. However, that doesn't come without complication. The healthcare industry has come a long way since 1999. The idea of patient safety and quality of care has come to the foreground and advancements have been made to improve patient outcomes and create a safer system. Despite so much change since the original report, clearly there is still much more to accomplish in quality and safety. Gandhi notes it is important to know how far we have come and recognize how much more hard work is left to do to reach the goals of the report that ignited the patient safety movement.

1. Kohn, L. T., Corrigan, J., & Donaldson, M. S. (2000). To err is human: Building a safer health system. Washington, D.C: National Academy Press. Chicago Retrieved from https://www.nap.edu/catalo/9728/to-err-is-human-building-a safer-health-system
2. Laerdal. (2019). Patient safety: An interview with Dr. Tejal Gandhi. Retrieved from: https://laerdal.com/us/information/2019-national-hospital-week/?utm_source=eloqua&utm_medium=email&utm_campaign=19-17488_Hospital_Week_EB&utm_content=button&elqTrackId=e40a0b3ff02e4c2d974903fb461fcc48&elq=e178d1d16eff490daa20e2a8edb4d9a0&elqaid=1363&elqat=1&elqCampaignId=866
3. Makary, M.A. & Daniel, M., (2016). Medical error-the third leading cause of death in the US. BMJ Clin. Res. Ed. 353, i2139.
4. Martin, Nina & Montagne, Renee (2017). U.S. has the worst rate of maternal deaths in the developed world. National Public Radio. https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world

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