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# THE PATIENT SAFETY FORUM

July/August, 2008

## PATIENT SAFETY & PERFORMANCE IMPROVEMENT: PERFECT TOGETHER

Walter A. Shewhart first discussed the concept of Plan Do Study Act (PDSA) in his 1939 book, *Statistical Method from the Viewpoint of Quality Control*. However, it was his protégé W. Edwards Deming who encouraged a systematic approach to problem solving and promoted the now widely recognized four-step process for continual improvement.

Deming refers to it as the PDSA Cycle (Plan Do Study Act) or the Shewhart Cycle. The model is used for the ongoing improvement of almost anything and it contains the following four continuous steps: **Plan, Do, Study and Act**, which involves cycles to continuously test change, measure and implement what works.



- Plan** Develop a plan for improving quality at a process
- Do** Execute the plan, first on a small scale
- Study** Evaluate feedback to confirm or to adjust the plan
- Act** Make the plan permanent or study the adjustments

The PDSA model, was used to implement *The University Hospital's* Early Response Team (ERT) program. Initially, the team reviewed pre-ERT rates of non-ICU codes and agreed that a reduction to 15% from pre-ERT levels would indicate success of their actions. The stretch goal for outstanding performance was set at 0% or no codes in non-ICU units once the ERT was deployed house wide.

Since the PI team was chartered, numerous change cycles have taken place, including the initial piloting of the ERT on several units, development of our "early warning signs," re-configuring the ERT, the rollout house wide to all adult units, and revisions of the nursing flow sheet to prominently display the early warning signs to trigger an ERT call. Data was analyzed to decide if a change that was introduced worked and should be retained or, if not, discarded.

**F Yellow** is a good model of a unit where nurses continually learn from their experience with ERT calls.



Staff members of F Yellow

Of all the non-ICU areas, F-Yellow has registered the most ERT calls for a 24-month period and has had only one or no code a month.

**Continue to improve and Call Early, Call Often, Save a Life Today!**



## PATIENT SAFETY

**The Patient Safety/  
Quality Improvement Department  
Welcomes  
Barbara J. Lopez, PA-C.**



Barbara Lopez joined NJMS Patient Safety/ Quality Improvement Department in May 2008 as the Quality Improvement Specialist.

A graduate of Bayley Seton Physician Assistant Program, Ms. Lopez has had an extensive career in clinical medicine and quality improvement. We look forward to working with her, as her wealth of knowledge will be an asset to our success in Patient Safety at the NJMS Faculty Practice.

**Medication Safety Initiative at  
NJMS Faculty Practice**

The Agency for Healthcare Research and Quality (AHRQ) studied 17 primary care practices across the United States in 12/06, and learned that none had guidelines in place for safe dispensing of sample medications. According to patients surveyed across the United States, 65% received verbal instructions, 4% received written instructions, 30% received both written and verbal instructions, and 1% received no instructions when given sample medications.

A pilot project to address this issue is currently in progress at Suite 4500 of NJMS Faculty Practice, led by Barbara Lopez. A sample medication log was created for purposes of inventory control and documentation of dispensed sample medications. This will provide a comprehensive tracking system to identify samples given to patients in the event of a recall or new box warning. Mechanisms are also in place to provide written drug information to patients. The implementation of these measures will help to reduce the chance of medication errors.



Barbara Lopez (c) with the staff from Suite 4500:  
L-R: Linda Rivera, Anjaya West, & Marylu Roman

**Committed to  
Hand Hygiene**



The Medical Intensive Care Unit (MICU) staff recently participated in a commitment exercise geared toward hand hygiene with

Alan Levin, Patient Safety Officer-UH, and Dr. Vincent Barba, Medical Director for Quality Improvement. The commitment brings staff together to ensure not only that they clean their hands, but that all visitors and healthcare workers from outside the MICU clean their hands upon entering the unit.

Hand Hygiene is a team effort on the MICU. Staff keeps an eye out for each other in case someone forgets to clean their hands on the way in or out of a patient's room. Jennifer Smith, Nurse Manager, said, "we take this very seriously and are diligent in preventing infection." Hand sanitizer is strategically placed at the entrance to the unit and outside each patient's room. When Jennifer does unit education, she shares with her staff that the CDC reports that there are over 1.7 million healthcare associated infections in American hospitals each year with 99,000 associated deaths.



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