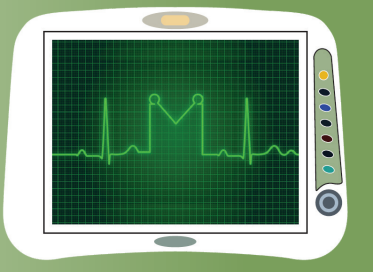
Medical Mutual Insurance Company of Maine

RISK MANAGEMENT

PULSE

Current issues and trends for hospitals and health systems



November 2019

Is your organization integrating Artificial Intelligence (AI)?

The American Hospital Association (AHA) released a report in September 2019, *AI and the Health Care Workforce* to assist hospitals with integrating. They stressed, "AI won't replace humans, and it will help them do what they do best — deliver care with a human touch."

The report gives definitions to help hospitals know the differences between artificial intelligence (AI), machine learning (ML) and robotic process automation (RPA). This report also gives insights and practical tips on how AI will change the healthcare landscape and how health systems should start preparing the workforce now. Access the AHA report AI and the Health Care Workforce to read more on how AI will change the healthcare landscape for the better.

American Hospital Association.
AI and the Health Care Workforce

Does your organization struggle with medication reconciliation?

Medication reconciliation is difficult in all settings and many organizations struggle. The Joint Commission recently released the 2020 National Patient Safety Goals (NPSGs), and medication safety is one of the top three. Learn how your organization can improve this important process to prevent adverse drug reactions.

The Hospital National Patient Safety Goals address reconciling medication information, under **Medication Safety-NPSG.03.06.01**. The rationale states that maintaining and communicating accurate patient medication information, requires medication reconciliation to be thorough to prevent adverse drug events. The Institute for Healthcare Improvement (IHI) has tools that can guide your facility on improving this process. According to the article Medication Reconciliation to Prevent Adverse Drug Events, reconciliation at all transitions of care is an effective strategy to reduce adverse drug events. There are many suggestions and tools at IHI to help you promote safety in your facility. Check it out!

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Does your frontline staff feel empowered to speak up?

According to an article in the Association of American Medical Colleges (AAMC), when all employees are empowered to speak up, performance will improve and errors will decrease. Read more to find out why psychological safety in medicine is so important.

According to critically acclaimed author and Harvard professor Amy Edmondson, PhD, psychological safety is critically important in medicine. In her interview, she gave some insightful suggestions on how to promote teamwork and a culture where staff feel safe to speak up and discuss errors. When staff feel safe and free to speak up, then errors can be prevented.

Is your fall program leaving patients worse than when they came in?

Kaiser Health News recently published an article titled 'Fear of Falling': How Hospitals Do Even More Harm by Keeping Patients in Bed. They reported that research shows that "one-third of patients age 70 & older leave the hospital more disabled than when they arrived." Is your fall protocol hurting your patients?

Hospitals are penalized for their fall rates when they are too high. As a result, patients are instructed not to get up without help and bed alarms are set. Many facilities do not have the staff to ambulate patients, which can lead to deconditioning, and require post hospital care such as SNF or Home Healthcare. According to the Kaiser Health News article, it is particularly dangerous for older patients since only a few days of bedrest can cause severe long-term consequences.

Has your length of stay increased since your organization has focused on falls?

Are the action items from Root Cause Analysis (RCA) going to prevent the event from occurring?

You have spent hours investigating an event in your organization, the RCA team meets, and action items are chosen. Are you confident the action items chosen will prevent it from happening again? Are your action items defined in a way that you can measure the effectiveness? If not, you are not alone.

The Maine Sentinel Event Newsletter, released in September 2019, has identified that many facilities only measure if an action item was completed and not the effectiveness. It is important to monitor an action item not only for effectiveness, but also to detect any unintended consequences. The newsletter references the Minnesota Adverse Events Measurement Guide that can help you develop strong action items that are measurable. This guide is comprehensive and has many ideas and tools to help you create action items that address the problem and structure them in a measurable way so you will know if your action items are successful.

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