Virginia Mason Medical Center boosts its rate of ‘perfect doses,’ in the May 2013 Issue of “The Joint Commission Journal on Quality and Patient Safety”

(Oak Brook Ill., May 02, 2013) Joint Commission Resources announces the May 2013 issue of the "The Joint Commission Journal on Quality and Patient Safety." In the lead article, “Using Lean to Improve Medication Administration Safety: In Search of the ‘Perfect Dose,’” Joan M. Ching, RN, M.N., and colleagues at Virginia Mason Medical Center in Seattle, Wash., report how their hospital used the Collaborative Alliance for Nursing Outcomes (CALNOC) Medication Administration Accuracy Quality Study, in combination with Lean quality improvement efforts, to substantially improve the safety of medication administration. In just 21 months, Virginia Mason Medical Center was able to decrease its rate of medication administration errors from 10.3 errors per 100 doses at baseline to only 2.8 errors at final follow-up. The article describes the specific methods that were used to reduce the medication administration error rate and increase the rate of achieving a “perfect dose” from 37 percent to 68 percent. A “perfect dose” reflects a health care organization’s adherence to the six safe practices for medication administration, such as comparing medication with the medication administration record, identified by CALNOC in conjunction with the absence of any of eight identified types of possible medication administration errors, such as a wrong dose.

“The Joint Commission Journal on Quality and Patient Safety,” published monthly by Joint Commission Resources, is a peer-reviewed journal, available by subscription, which serves as a forum for practical approaches to improving quality and safety in health care.

FEATURES:
Medication Safety
Using Lean to Improve Medication Administration Safety: In Search of the “Perfect Dose”
Joan M. Ching, RN, M.N.; Christina Long, RN, B.S.N.; Barbara L. Williams, Ph.D.; C. Craig
Blackmore, M.D., M.P.H.
At Virginia Mason Medical Center in Seattle, Wash., the number of medication administration
errors across 13 inpatient units decreased from 10.3 errors per 100 doses at baseline to 2.8
errors at final follow-up, after implementing a series of improvements using Lean tools. The
“perfect dose” score, reflecting compliance with all six designated safe practices and absence of
any of the eight identified types of medication administration errors, improved from 37 in
compliance per 100 doses at baseline to 68.

A Multicenter, Multidisciplinary, High-Alert Medication Collaborative to Improve Patient
Safety: The Singapore Experience
Ai Leng Khoo, Ph.D.; Monica Teng, M.H.Sc.; Boon Peng Lim, B.Pharm. (Hons); Hwei Yee Tai,
A multicenter, multidisciplinary, high-alert medication collaborative, established in Singapore in
2009, has provided a sound framework for ongoing development and refinement of high-alert
medication change packages and for sharing of adverse drug event data and best practices
across the participating institutions.

Teamwork And Communication
Measuring Handoff Quality in Labor and Delivery: Development, Validation, and
Application of the Coordination of Handoff Effectiveness Questionnaire (CHEQ)
Michael Block, M.D.; Jean F. Ehrenworth, R.N.C., M.S.N.; Virginia M. Cuce, R.N.C., M.S.N.;
Njoki Ng’ang’a, M.Sc., R.N.C.; Jacqueline Weinbach, RN; Shelley Saber, M.D.; Milija Milic,
M.D.; Judith A. Urgo, R.N.C., M.S.N.; Desiree Sokoli, APN-C; Mark D. Schlesinger, M.D.; J.
Bryan Sexton, Ph.D.
A new questionnaire measures the quality of both shift-change and intrashift handoffs in labor
and delivery (L&D) in terms of information transfer and the interaction process. The
questionnaire may help other units gain insight into the team dynamics of L&D to advance
perinatal quality improvement work.

Enhancing the Effectiveness of Follow-Up Phone Calls to Improve Transitions in Care:
Three Decision Points
Marian Bihrlie Johnson, M.P.H.; Mara Laderman, M.S.P.H.; Eric A. Coleman, M.D., M.P.H.
Improving communication and coordination of care, including enhancing communication with
patients and families, can reduce readmissions within 30 days of discharge. Telephone follow-
up (TFU) was examined as a component of postdischarge processes among hospitals and
organizations participating in the STate Action on Avoidable Rehospitalizations (STAAR). Optimal TFU entails three decision points: who should make the call, what information is essential, and what is the optimal timing, frequency, and duration of follow-up calls.

DEPARTMENTS:

Case Study In Brief

Using an Assessment Tool to Identify Risk of Osteopenia in Infants and Prevent Fractures

Shantanu Rastogi, M.D., M.M.M.

At a regional perinatal center, the neonatal ICU used its Fracture Risk Assessment Tool to identify 50 infants with osteopenia among 1,462 admissions between January 2009 and December 2010 who were at risk for fractures.

Forum

A Framework for Patient Safety: A Defense Nuclear Industry–Based High-Reliability Model

David J. Birnbach, M.D., M.P.H.; Lisa F. Rosen, M.A.; Lorena Williams, M.S.; Maureen Fitzpatrick, M.S.N., ARNP-BC; David A. Lubarsky, M.D., M.B.A.; John D. Menna, Ph.D.

The nuclear power industry has frequently served as a high-reliability model for health care organizations. However, the experience of the U.S. Department of Energy defense nuclear industry can also provide guidance, as reflected in seven principles for a patient safety management system.


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