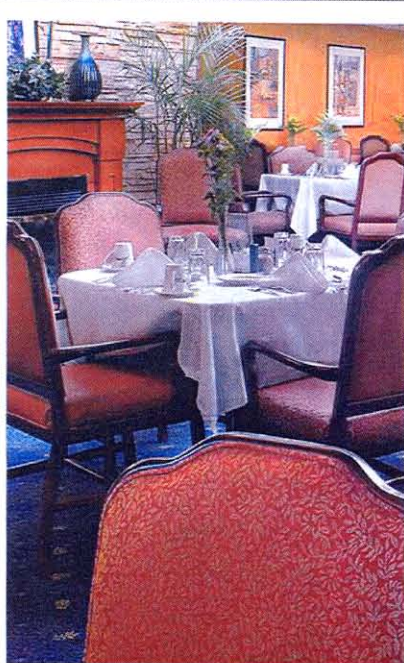




Ode Keil, Senior Editor

Contributing to a Culture Of Patient Safety



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The healthcare industry may have finally settled on a quality issue that will not be the flavor of the month. Patient safety has proven to have more staying power than previous quality initiatives, such as continuous quality improvement (CQI) and total quality management (TQM). It is different in an important way: Patient safety deals with real issues that affect people's lives. The other programs deal with abstract ideas that need to be applied to real-world situations.

When CQI and TQM were the focus of quality initiatives, healthcare organizations had a difficult time sustaining interest in the processes once they had completed educating the staffs. Patient safety provides a continual flow of opportunities to improve that may require the use of CQI and TQM concepts.

At present, the advantage of patient safety is that organizations such as the Institute of Medicine (IOM), the National Patient Safety Foundation (NPSF), the Institute for Safe Medication Practice (ISMP) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) keep pushing new challenges at healthcare organizations. Each organization has a self-interest with respect to patient safety. The professional groups that make up the organizations are challenged to be part of the effort to reduce patient safety risks by participating in the programs the organizations propose. For example, JCAHO publishes its annual list of patient safety goals that accredited organizations must address in order to maintain accreditation. The ISMP has developed programs that hospital pharmacy staff can use to assess and modify risks. Each organization is contributing to the development of a culture of patient safety by taking an active role in addressing an issue relevant to the members of the group.

A unique group of hospital-based biomedical or clinical engineers is working to establish a similar opportunity for the members of this professional group. The American College of Clinical Engineering Healthcare Technology Foundation (AHTF) has undertaken several initiatives of interest to biomedical and clinical engineers. The issues also relate to clinical care providers and patients. Two examples of the work being done by the group are development of materials to address the risks of clinical alarms and development of educational materials that can be used by clinical engineers, clinical and staff and patients.

The alarm initiative includes gathering of real-world information about alarm-related patient

safety incidents and gathering, through a survey, information about the attitudes and beliefs of nurses related to clinical alarms. The educational materials are designed to educate clinical engineers and clinical staff to the risks of various types of equipment or policies. One publication in the works addresses the risks of allowing patients to bring personally-owned medical equipment to the hospital for use during a stay. This is a tricky issue because many of the patients cannot afford the cost of using a hospital-owned piece of equipment. At the same time, hospital staffs are not familiar with the equipment and often do not have supplies and accessories available to ensure safe and reliable operation of the equipment.

This work is a significant contribution to the engineering presence in a hospital. It links engineers directly to the patient safety process in a manner very different from the traditional role of maintaining and testing equipment. It is the first widespread effort that does what I have often asserted is the role of the hospital engineer: to educate staffs and patients. Through education, the hospital engineering community can do more to improve the culture of patient safety than it can by maintenance and testing. The difference is that education changes awareness and attitudes while maintenance and testing provide a handy excuse to ignore operational risks of equipment.

The AHTF has done a good job of getting the ball rolling. Two questions now confront hospital engineers: Will the local engineers pick up the information and do what other professions have done with similar information to improve local operations? And will other professional groups establish working groups to further this work in other areas of hospital engineering? If both of these questions are answered in the affirmative, the healthcare industry will benefit greatly from the effort. FC

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