Quality Safety Advocate Council

University of Colorado Hospital
ANSCHUTZ MEDICAL CAMPUS

Monday, April 28, 2014
12:00 – 1:00pm
AIP2, Conference Room B

Minutes

Meeting called to order by Courtney West — Recorder: Sharon Ostrom

Attendees: Sharon Ostrom, Sondra May, Keri Gulliford, Kelly McIntosh, Mark Horn, Sandy Godcharles, Madelin Adames, Jennifer Livinston, Claudia Scraggs, Timothy Pratt, Nicole Babu, Wendy Cyriacks, Ann Whathy, Shawna Parrish, Terry Shade, Sylvia Park, Joe Jazinski, Courtney West, Emily Young, Barb Turner, Kim Olsen, Sue West, Cindy Danahey, Gwen Marsh, Janna Petrie

Relationship to Magnet Components:

Exemplary Professional Practice

EP16 Interdisciplinary collaboration across multiple settings to ensure the continuum of care.

Culture of Safety. Describe and demonstrate

EP30 The structure(s) and process(es) used by the organization to improve workplace safety for nurses.
EP31 How the organization uses a facility-wide approach for proactive risk assessment and error management.
EP32 The nursing structure(s) and process(es) that support a culture of patient safety.

Quality Care Monitoring and Improvement. Describe and demonstrate

EP33 The structure(s) and process(es) used by the organization to allocate and/or reallocate resources to monitor and improve the quality of nursing and total patient care. The nurse has responsibility for ensuring the coordination of care among other disciplines and support staff.

Agenda Item	Presenter(s)	Discussion	Recommendation/Action
Approval of March 2014 Minutes	Courtney West, Sharon Ostrom	Motion to approve and a second motion obtained.	Minutes unanimously approved
Welcome new members	Courtney West	• Welcome and introduction of new members • Reminder to sign in – members must have 75% attendance	No recommendation/action

Annual Clinical Excellence & Patient Safety Committee presentation	Sondra May	• Sondra is co-chair of the medication safety steering committee. The philosophy of the committee is that errors will happen. Over the past four years, the total number of medication errors has increased, but the percent of errors has decreased due to the increase number of medications given. • Currently 37% of Significant Incidents submitted regarding med errors are Near Misses, and this is a good number. • Bar Code Compliance for 2012 to 2013 has increased 5%. This equates to a decrease of 50% in medications not scanned, which is approximately 300,000 doses a month. • Since bar code scanning started in the ED there has been a 44% decrease in administration errors. • With the standardization of PCA medications there has been a decrease of patient occurrences of 30%, a 52% decrease ins wrong concentration occurrences, and a 100% decrease of wrong mode programming occurrences. • Future initiatives include having BPAs alert MDs when	• QSA should distribute this information to staff on their unit.

		a medication has stopped due to an Automatic Stop Order (ASO). Specific orders will have a 12-hour alert if a patient received the medication already as a one-time order (i.e.: antibiotics, loading does of a medication, aminoglycosides).	
MSPCU Lab Labeling FOCUS-PCDA	Becky Breidenstein & Tim Pratt	• Janna Petrie sent this presentation out via e-mail	The QSA should distribute this information to staff on their units.
QSA Project: Campaign to decrease Lab Errors and Blood Bank Errors	Courtney West	• See Handouts • Overall Errors have decreased •	• A mini task force will meet prior to the May QSA meeting to develop a plan of action. • Ideas will be shared with QSAs to implement on their unit.
March Good Catch	Janna Petrie	• Meeting time was up. Plan to review good catches at May meeting.	• QSAs were encouraged to submit "good catch" nominees to Janna Petrie for consideration.
			Next meeting – Monday, May 19, 2014 – AIP2, Conference Room D

Respectfully submitted: Sharon Ostrom RN, BSN, PHN, CMSRN