PART III

Patient Safety

Patient Safety

- HC has two implicit moral/ethical promises to patients that entrust their care to us, we promise to:
  - Do everything possible to help them
    - Meeting external minimum standards
  - Not hurt them
  - Thus, Freedom from injury due to healthcare

Preventable Harm in Healthcare

- ~5% of patients are exposed to harm
- >3 million LMIC deaths occur annually to Patient Safety incidents
- >50% of patient harm is preventable:
  - The most common (JCI): Poor Communication
    - Miscommunication
    - Communication failure
    - Communication breakdown
    - Lack of adequate communication
  - Medication errors
- A large % of Patient Safety incidents are underreported
  - Culture of Blame makes clinicians reporting incidents fearful

Healthcare (HC) “Systems”

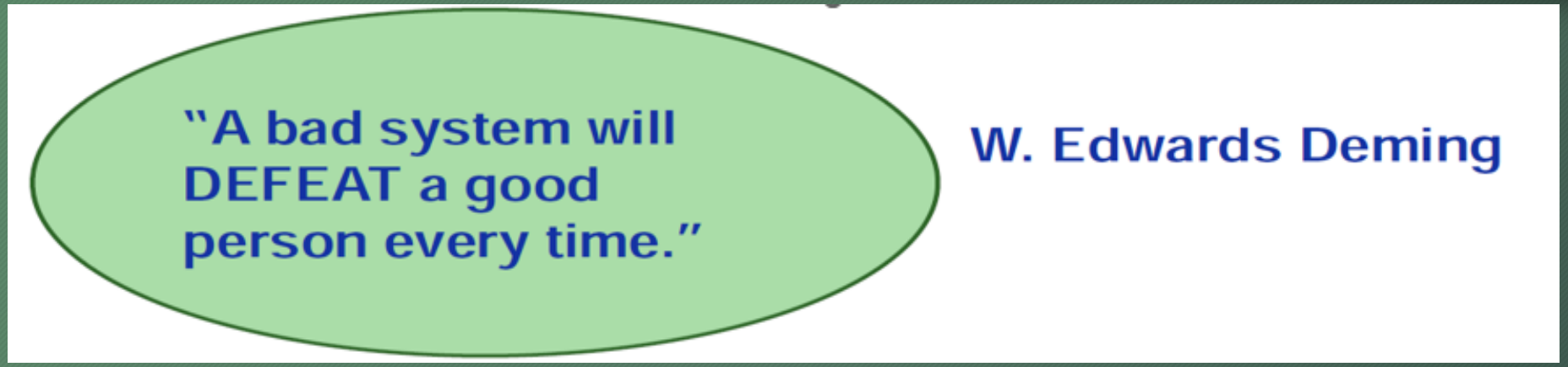
Using a “Systems Thinking” approach:

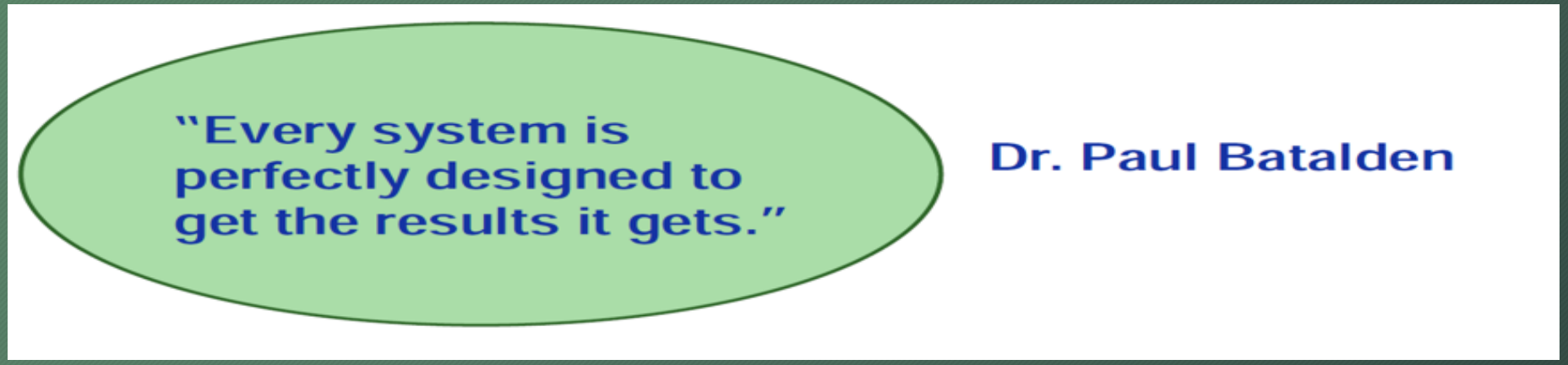
A hospital is a system; and that system can and must be designed to compensate for the errors that are likely to be made by any of its components

Systems Thinking:

- Systems thinking is not easy; it is not a natural act: we see the parts not the whole
- But to master the art of Patient Safety we must have a deep and fundamental understanding of how the parts are connected in our entire complex Healthcare system
- “We must accept human error is inevitable – and design around that fact.” - Don Berwick, M.D.
- “The Search for zero error rates is doomed from the start”

“Systems” Principles





Systems Thinking

- "Running a Hospital isn't Brain Surgery….

  It's Harder!"

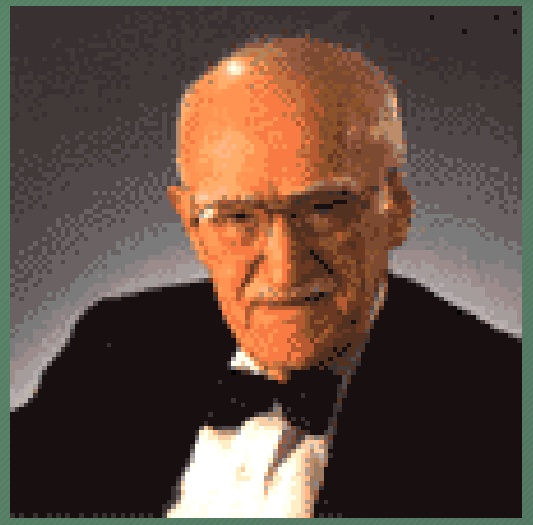
We are human. We will never eliminate all errors. The real goal is to prevent harm to patients

Systems Thinking

- “Healthcare Organizations are the most complex organizations to manage”

Peter Drucker

“System” = Main Cause of Harm



Joseph Juran

80+%

Poor Performance Due to the **Design** of the **System**

<20%

Poor Performance due to the efforts of the **People** in the **System**

Normal Response to a Medical Error

- Go directly to the staff members involved (the sharp end of the chisel)
  - The Physician/medical residents
  - The Nurse
- However, this is counter to a Safety Culture ("Just Culture") concept:
    - Do not automatically blame the caregiver
    - Instead, thoroughly investigate the incident
  - Root Cause Analysis:
    - RCA is the process that seeks to explore all of the possible factors associated with the incident by asking what happened, why it happened and what can be done to prevent it from happening again

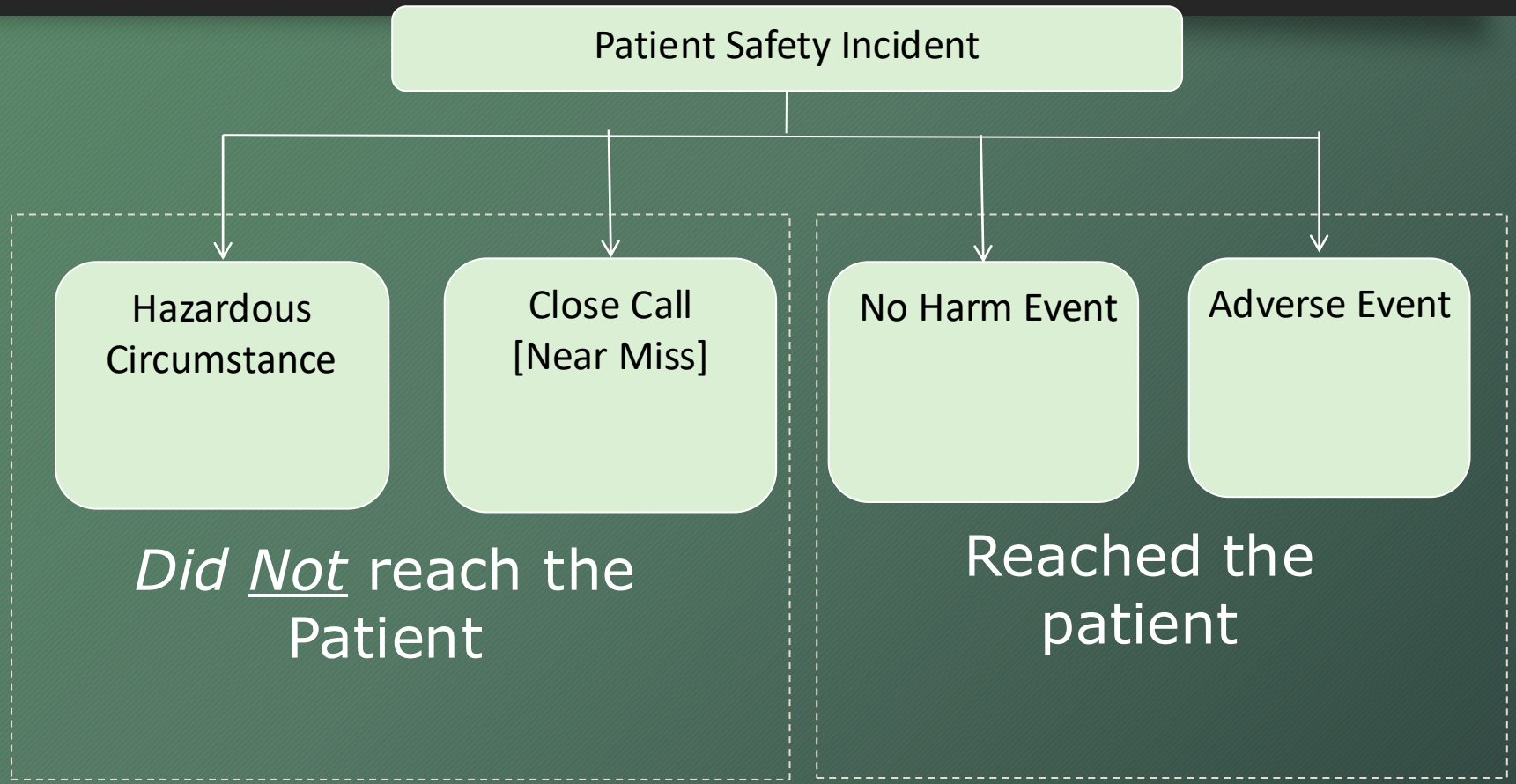
Sentinel Event

- An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof:
  - Surgery performed on the wrong side or wrong site
  - Unexpected patient death
  - Serious medication adverse event
  - Maternal death around delivery
  - Patient suicide
  - Severe transfusion reaction
- Serious injury includes loss of limb or function (includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome)

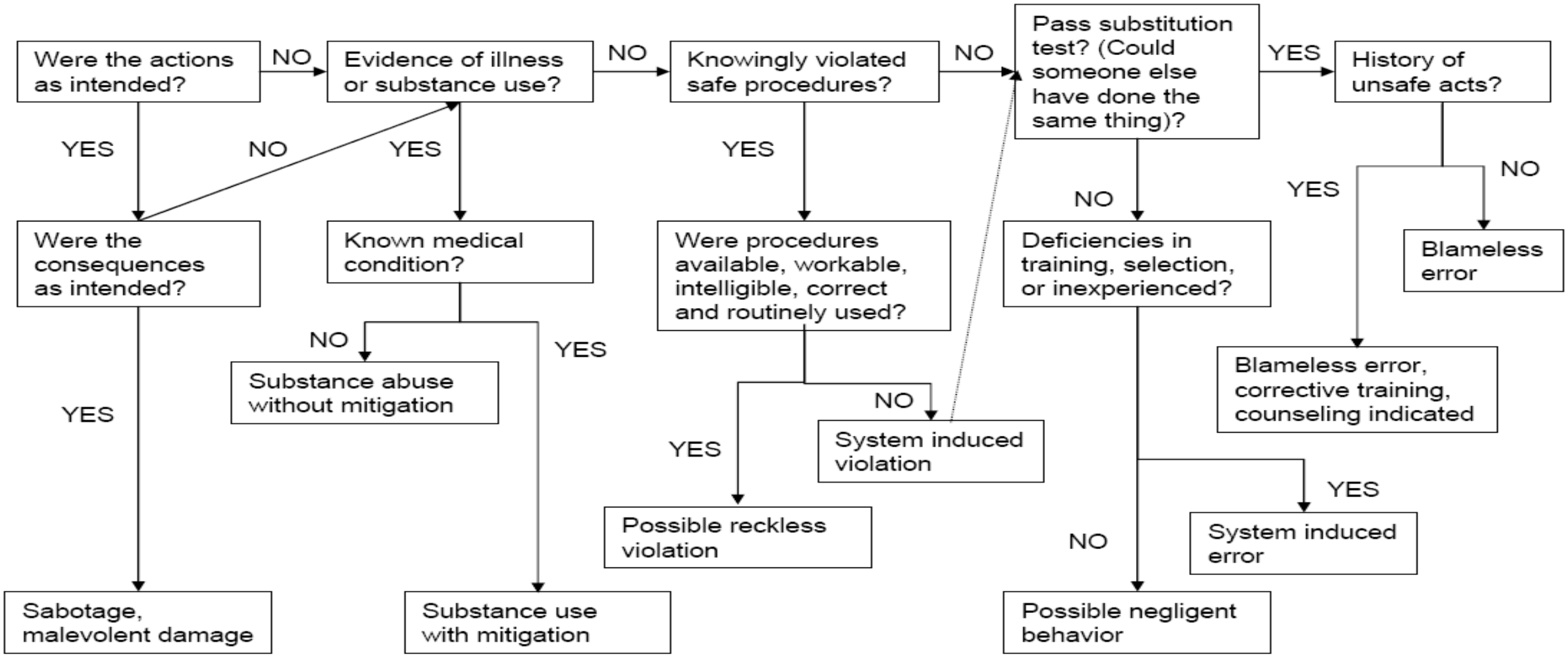
“Near Misses”

- "Near misses are the huge iceberg below the surface where all the future errors are occurring”
- Close calls should be given the same level of scrutiny as adverse events that result in actual harm:
  - They are 3 to 300 times more common than actual adverse events
- It is as important, if not more important to evaluate a near miss than evaluating an actual misadventure that resulted in patient harm
- A willingness and a way (means) to report problems is essential to safe care because *you can’t fix what you don’t know about*

Defining a Patient Safety Incident



UNSAFE ACTS ALGORITHM



Adapted from James Reason. (1997). Managing the Risks of Organizational Accidents.

“Just Culture”

James Reason:
Culture is a collective understanding of where the line should be drawn between blameless and blameworthy actions

Usual Approach to Human Error

- Traditional: a "**Retributive culture" focused on individual Blame [directly blaming the staff member(s) involved]**
  - Due to: Violations of rules with Individual liability
    - Gradation of penalty according to error
- **Focus: punishing individual misconduct**
- Result:
  - Hinders HC from learning from mistakes
  - Frequently, mistakes are covered up by the fear of punishment

[New] A "*Just* Culture"

- Requires a fair and transparent method to investigate mistakes (no fear); ask:
  - Was the harm purposeful? Rare
  - Did this result from human error?
    - If yes,
      - At risk behavior- a choice to consciously disregard risk = action: education/coaching
      - Reckless behavior – punitive action
    - If no, review behavior and system processes

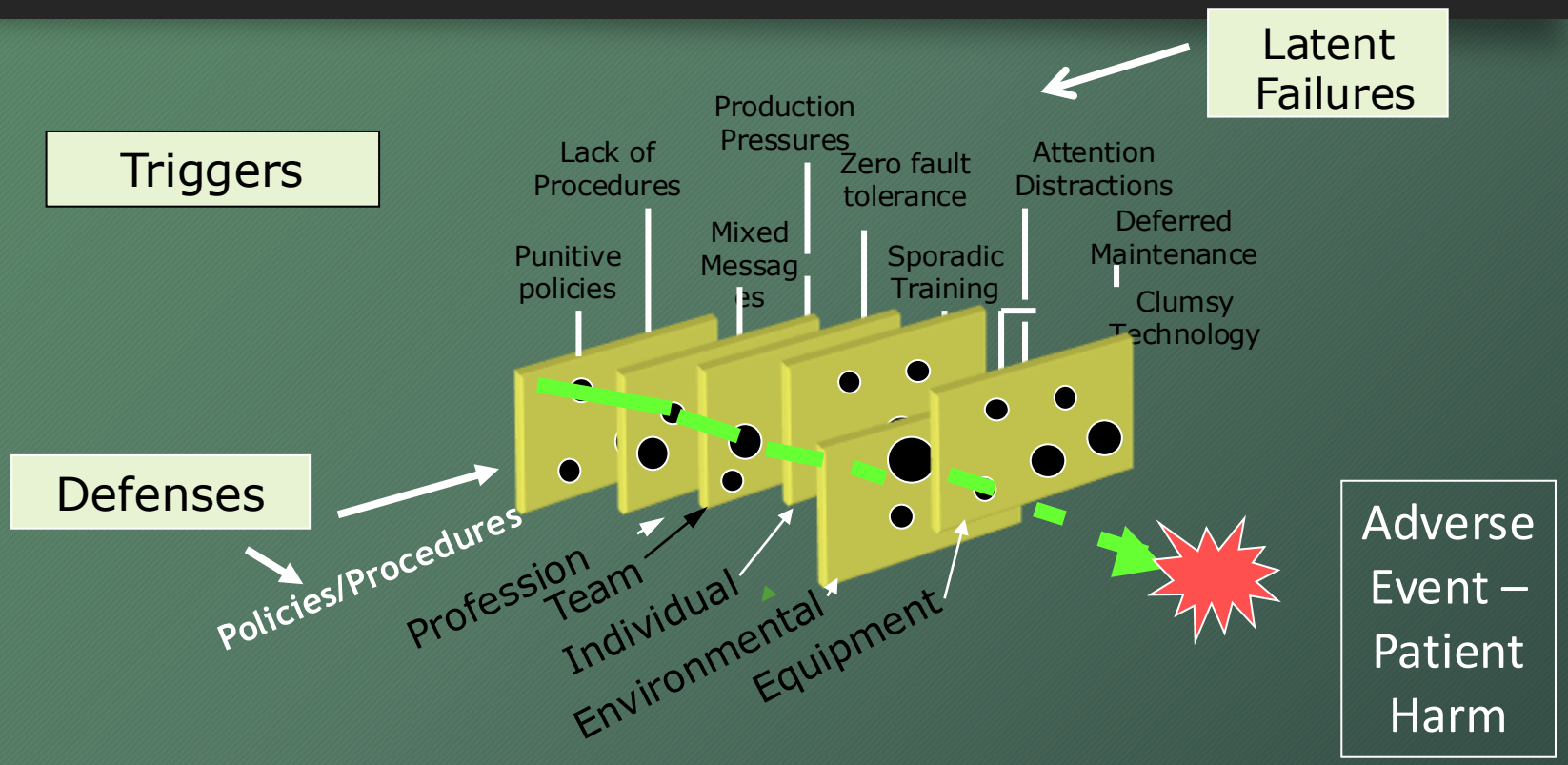
Root Cause Analysis (RCA): When a Patient Safety Event Occurs

- Immediately begin extensive Discussion by multi-disciplinary RCA team:
  - Establish a timeline - what happened? Who was involved?
  - Review the Medical Record; Interview those involved
  - Do not settle for an easy answer; Ask the 5 why's – find the incident's root cause
- End with a short Concise Document: [Present to CEO in <45 days]
  - Clear description of the Issue(s)
  - Actions to be taken to ensure it doesn't happen again:
    - Who will do the action
    - Date change in system (Policies +) to be completed
- Always have Quality Committee follow-up –document

Root Cause Analysis (RCA) Report

" Hospital"					
ROOT CAUSE ANALYSIS REPORT					
Date RCA Team Started:		Date RCA Team reported to CEO (Goal < 45 days):			
Issue #	Description of Process to Change	Suggested Changes	Time Fame to accomplish change	Responsible Person	CEO Response/Rationale	Follow up (document)
1						
3						
4						
5						
6						
7						

The *Swiss Cheese* Model (Reason, 1991)



Culture of (Psychological) Safety

Culture

- Definition: The Shared basic assumptions, norms, and values and repeated behaviors of a group into which new members are “socialized”
  - Culture is “the way things are done around here”
- Diverse cultures may exist in even in a small hospital
  - if a culture of safety and quality pervades an organization, they will be successful

- “Every System is perfectly designed to get the results it gets”
- “Culture eats strategy for Breakfast”

A Health Care System
Includes your visible Policies, Procedures and Strategies; however,
your organization's Culture (the hidden part of your "System")
is the major determinant of how well you deliver high quality care

Strategy/Procedures /Programs/Policies

Organizational culture

“Culture of Safety”

- Requires a fair and transparent method to investigate mistakes (no fear)
  - Was the harm purposeful? Rare
  - Did this result from human error?
    - If yes,
      - At risk behavior (a choice to consciously disregard risk) – action: education/coaching
      - Reckless behavior – punitive action
    - If no, review behavior and system processes

New “Culture of Safety” Paradigm

- James Reason–”Culture of Safety” protocol
  - Learn from mistakes, not “blaming”
  - Staff willing to report safety issues (dare to speak up)
  - Staff who trust each other’s commitment
  - System is Flexible: able to adapt and alter processes
  - Prevent future harm
  - Organization known for ‘Open Communication”

Psychological Safety

- In an institution with psychological safety there is a climate of:
  - Respect
  - Trust
  - Openness
- Where staff can raise concerns and suggestions without fear of reprisal
- Psychological Safety Is the foundation for a “learning culture”

Culture of Safety "Not"

- A system totally "Blame-free"
  - Errors from using drugs/alcohol
  - Errors from a direct disregard for safety
  - Malicious behavior
  - Errors from suspected patient abuse
  - Purposely unsafe acts
- Individual Accountability is maintained
- A balance, neither a strictly punitive culture or a blame-free culture

Patient Safety

- Integrating Patient Safety into practice is a very complex process in that it interacts with both clinician practice and the institutional “System” itself
- HC systems must be built on a “Culture of Safety”

- A Culture of Safety is a system designed to prevent errors while empowering individual staff members to promote safety and recognize and respond to errors that occur

International Patient Safety Goals

1. Improve the accuracy of patient identification:
   - Two patient identifiers
   - WHO “Time Out Process:” Prior to the start of any invasive procedure conduct a final verification process to confirm that all team members understand:
     - You have the correct patient,
     - You are doing the correct procedure,
     - On the correct site,
     - With the availability of appropriate ancillary data,
     - “Time-Out” is documented

International Patient Safety Goals

2. Improve the effectiveness of Communication among caregivers:
   - Verbal and telephone orders or critical test results – require “read-back” verification
     - Never document with unapproved abbreviations, acronyms or symbols (“Do Not Use” list)
     - Reporting and receipt of critical (Lab or Imaging) test results and values must be timely (<60 minutes)
   - Standardize “hand off” communications including time to ask and answer questions (such as SBAR)


WATCHDOG GROUP PROMOTES STRATEGY TO END MEDICAL ERRORS
YOU'LL BE HAPPY TO KNOW WE HAVE NEW PROCEDURES THAT'LL PREVENT MISTAKES, MRS. BROWN.
My name is Smith

International Patient Safety Goals

3. Improve medication safety:
   - Your Pharmacy should only stock the lowest Electrolyte solution concentrations
   - Actions are taken to prevent look-alike and sound-alike medication errors
   - Label all medications/syringes and solutions used in OR and Procedure areas
4. Reduce the risk of health care-acquired infections:
   - Comply with hand hygiene guidelines: wash hands for at least 15 seconds before and after delivering care or use alcohol-base hand gel
   - Manage all unanticipated death (s) or major permanent loss of function associated with a healthcare acquired infection as a sentinel events

International Patient Safety Goals

5. Accurately and completely reconcile medications across the continuum of care:
   - Obtain, document, compare and reconcile medications for inpatients and outpatients; involve the patient. Repeat the process if changes in provider or setting. Provide the patient with a copy of the reconciled medication list

6. Reduce the risk of patient harm from falls:
   - Implement a fall reduction program and evaluate the effectiveness of the program