A Sense of Urgency: Patient Safety

Suzanne Anders, RN, BSBA, CPHQ
Health Services Advisory Group
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Presentation Objectives

- At the end of this session, participants will better understand:
  - The need for a sense of urgency for assessing patient safety within their organizations.
  - Patient safety concepts and ideas that may not have been considered within their organizations.
  - The need to challenge organizational leaders to become as familiar with patient safety as they are with financial statements.

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Culture

. . . a set of assumptions and practices that allow people to construct a meaningful set of ideas about risk, danger, and safety.

Predispositions Toward a Culture of Safety in a Large Multi-facility Health System

Integrated pattern of individual and organizational behavior, based upon shared beliefs and values, that continuously seeks to minimize patient harm.

Patient Safety, Achieving a New Standard for Care

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Assumptions About Patient Safety

- It's new.
- It's a trend.
- If we ignore it long enough, it will go away, become mandated, or become profitable.

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Overheard Statements

1. I hate to call Dr. Leavemebe. He is so rude when I try to talk to him about his patients.
2. Did you hear about the med error Sally made? Thank God it wasn't me!
3. We don't need to fill out an incident report; nothing really happened to the patient.
4. Don't worry about this new piece of equipment. It's easy to use; you'll be able to figure it out all by yourself.

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Overheard Statements

5. I know this is not what the policy says, but this is easier; policies don't think or always make sense.
6. Guidelines and standardized processes are cookbook care.
7. Turn the music down so I can think.

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Practices Surrounding Safety

- Communication
- Events
- Near Misses
- Human Factors
- Safety Processes
- Distractions
- Accountability

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Communication

- Physician personality stereotype
- Hand-off communication
- Notes about progress and care
- Documentation of communication
- Speak-up campaign
- Informed consent

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Improving Patient Communication for Safety's Sake

- "For your safety"
- Appreciate informed patients
- Face-to-face communication for discharge teaching

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Events

- Reported versus actual
- Consequences
- Disclosure
- Liability

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Near Misses

- "…an act of commission or omission that could have harmed the patient but did not do so as a result of chance, prevention, or mitigation." *Patient Safety*
- Opportunity to maximize learning
- To report or not to report

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Improving Event Reporting for Safety's Sake

- Report and discuss near misses
  - Staff meetings
  - Committees
- Assess the perception of incident reports by clinicians

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Human Factors Defined

- Human factors involves working to make the environment function in a way that seems natural to people.

http://en.wikipedia.org/wiki/Human_factors

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Human Factors

- Principles of human factors:
  - \+ Strengthen processes
  - – Are often contributing factors to events and near misses
  - \+ Assist in work redesign
  - +/– Can act as the interface between man and tools

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Improving Human Factors for Safety's Sake

- Supplies
  - Availability
  - Organization
- Equipment
  - Standardization
  - Education
- Alarms
  - Default
  - Level of intensity

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Processes

- B teams with A processes will beat A teams with B processes.

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Safety Processes

- Checklist
- Standardized
- Redundancy
- Simplification
- Forcing functions
- Interrupt-free zone
- Prompts and reminders

Improving Processes for Safety's Sake

- Limit one protocol per process
- Develop documentation aides to support processes
- Simplify forms

Interruptions, Distractions and Interferences

- Interruption: Cessation of a task before its completion
- Distraction: External stimulus causing a human response but not cessation of a task

For Example: Interruptions and Distractions

- 1,7,4,2
- Dinner 3 nights ago
- Dinner on Sunday

Decreasing Interruptions, Distractions, and Interferences for Safety's Sake

- Noise levels
- Interrupt-free zones
- Do Not Disturb

Observed Behaviors

- Human error
  - Inadvertent action, slip, lapse, mistake
- At-risk behavior
  - Increases risk where risk is not recognized or is mistakenly believed to be justified
- Reckless behavior
  - Choose to consciously disregard a substantial and unjustifiable risk

Just Culture

Behavioral Accountability

- Human error – console
- At-risk – coach
- Reckless – punish

Just Culture

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Hierarchy of Actions

- Stronger Actions
  - Involvement and action by leadership
  - Simplify the process
  - Standardize equipment
- Intermediate Actions
  - Checklist, cognitive aid
  - Reduce distractions
- Weaker Actions
  - Training
  - New procedure
  - Additional study

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Improving Accountability for Safety's Sake

- Investigate all of the contributing factors leading to a reportable event.
- Look for solutions beyond inservices and education.

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Responsibility and Accountability for Patient Safety

- Executive leadership, including the Board of Trustees
- All management
- All providers of care
- All ancillary and support team members

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Patient Safety Barriers

- CEO does not hold himself responsible and accountable
  - The Patient Safety Officer (PSO) is not empowered by the CEO
  - The PSO reports to someone other than the CEO
- The PSO is not part of the senior management team
- Investigations result in punitive or corrective actions rather than improved process

CRG Medical Foundation for Patient Safety

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Beginnings

- Assess current climate of safety.
- Review high-risk processes to assure that they include principles of safety.
- Determine barriers that are preventing people from talking about safety issues.
- Be passionate about what you do, listen to stories, act as a consultant, share information, and work to develop a shared vision.

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Contact Information

Suzanne Anders, RN, BSBA, CPHQ
- sanders@azqio.sdps.org
- 520.661.9370

Judith Richard, RN, MS, CPHQ
- jrichard@azqio.sdps.org
- 602.665.6116

http://acute.hsag.com

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