Uncovering Patient Safety and the “Just Culture” Theory

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Speaker

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Learning Objectives

1. Explain the National Quality Forum’s 34 Safe Practices for better healthcare.
2. Recall the 10 published AHRQ patient safety tips for hospitals.
3. Define the “Just Culture” theory.
4. Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
5. Evaluate compliance requirements and penalties.

Patient Safety and Just Culture

- As we steer our hospitals toward the idea of a nonpunitive or blameless culture how do we balance this with the concept of accountability?
- Holding individuals accountable for mistakes is now more complex than ever
- How do these four behavior concepts differ?
  - Human error
  - Negligence
  - Reckless conduct and
  - Knowing violations
The Faces We Should Remember

- Ben Kolb, a 7 year old scheduled for elective ear surgery
- The surgeon injected with Lidocaine around the ear to numb the area
- He went in a cardiac arrest and died
- Martin Memorial Hospitals does a full investigation
- He had accidentally been given concentrated Epi which was poured into a unmarked sterile container

Betsy Lehman

- Betsy Lehman was a health reporter for the Boston Globe
- It was her last day at Dana Farber Hospital
- She was getting packed up to go home after having a harrowing course of chemotherapy for breast cancer
- An hour later she is dead
- Given an overdose of the chemo and instead of 6.5 grams over four days she had 26 grams
Josie King

- Josie King died at 18 months from dehydration and as a result of a hospital error
- Condition H now allows families to call a RRT
- Sorrell King has started a foundation to improve patient safety in healthcare

The Study We Have All Heard

- The Institute of Medicine (IOM) study “To Err is Human; Building a Safer Healthcare System”
- Adverse events occur in 2.9 to 3.7% of all hospitalizations
- 44,000 to 98,000 patients dies a year as a result of medical errors
- Source at http://books.nap.edu/openbook.php?isbn=0309068371
IOM Report

- The IOM report made a number of recommendation on patient safety
- Facilities should have a non-punitive system to report and analyze errors
- A team should be assembled
  - Team work can improve patient safety
- Safety program should be initiated using well established safety research

Adverse Events Among Medicare Patients

- HHS study finds a high rate of Medicare patient deaths due to adverse events (AE)
- 15,000 Medicare patients experience an AE during healthcare delivery that lead to their death every month
- Nov 16, 2010 OIG study
  - Found 1 in every 7 discharges (13.5%) experience an AE
  - 44% of all AE were preventable
- November 2010, OEI-06-09-00090
OIG Study 2012 and CMS in 2013

- OIG is doing a series of studies and included one that found that hospital incident reporting systems do not capture most patient harm
- CMS came out with a memo to encourage hospitals to report AE to the hospital’s PI program
- The list would help educate staff about the range of patient harms
- Would assist hospital administrators in assessing incident reporting systems
  - Many do not report because of afraid of punitive actions
  - Do you have a non-punitive response to error??
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

HOSPITAL INCIDENT REPORTING SYSTEMS DO NOT CAPTURE MOST PATIENT HARM

January 2012 OEI-06-09-00091

Report Adverse Events to PI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Center for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-10
Baltimore, Maryland 21244-1000

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: March 15, 2013
TO: State Survey Agency Directors
FROM: Director Survey and Certification Group
SUBJECT: AHRQ Common Formats - Information for Hospitals and State Survey Agencies (SAIs) - Comprehensive Patient Safety Reporting Using AHRQ Common Formats

Memorandum Summary

Hospitals are Required to Track Adverse Events: The Condition of Participation (CoP) for Quality Assessment and Performance Improvement (QAPI) at 42 CFR 482.21(a)(2) requires hospitals to track adverse patient events. However, several recent reports completed by the Department of Health and Human Services Office of the Inspector General (OIG) indicated that hospitals fail to identify most adverse events.

Use of the Common Formats May Help Hospitals Improve Tracking: The OIG suggested staff failure to understand what events need to be reported to the hospital’s QAPI program contributes to the problems with internal tracking systems. The OIG recommended that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) could help hospitals improve their ability to track adverse patient safety events by disseminating information on AHRQ’s Common Formats. The Common Formats define a systematic process for reporting adverse events, near misses, and unsafe conditions, and allow a hospital to report harm from all causes. Hospital use of the AHRQ Common Formats is voluntary, but a hospital that uses them and is adept at the analysis that they permit will be in a better position to improve patient safety.
Adverse Event Reporting

- Hospitals are required to track AE
- Several reports show that nurses and others were not reporting adverse events and not getting into the PI system
- OIG recommends using the AHRQ common formats to help with the tracking
- States could help hospitals improve the reporting process
- Encouraged all surveyors to develop an understanding of this tool
Hospital Common Formats

CMS will start reporting each hospital’s scores and reduce payments by 1 percent to hospitals with the highest rate of medical errors and infections in 2015.

CMS cut payments to hospitals with a high readmission rates as of October 2012 hospitals were penalized 280 million dollars and 217 million in 2014.

Hospitals will need to redesign and reengineer the discharge process to ensure proper reimbursement.

Hospitals should proactively look at ways to reduce medication errors and adverse events now.
Patient Safety Issues

- There are many patient safety issues
- Inpatient suicides, medication errors, wrong site surgery, restraint injuries, elopement, falls, retained foreign objects (RSI or retained surgical items), delay in diagnosis, infant abduction, misdiagnosis, communication errors, transfusion errors, surgical site infection, Heparin complications, Warfarin complications, critical lab results, skin tears, awareness during OR, OR fires, MRI safety, infections like MRSA and VRE.

Patient Safety Culture

- Dr. Don Berwick said “Every system is perfectly designed to achieve exactly the results it gets.”
- Dr. Lucian Leape said “Management must ‘manage’ for patient safety just as they manage for efficiency and profit maximization. Safety must become part of what a hospital or health care organization prides itself on.”
- Much has been written on establishing a patient safety culture and doing a patient safety culture survey to measure where the facility is located on the patient safety continuum.
Definition of Patient Safety

A patient safety practice is defined as:

- A type of process or structure whose application reduces the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures
- Patient safety is the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery
  - Defined by AHRQ (Agency for Healthcare Research and Quality) and NQF (National Forum for Quality Measurement and Reporting)

Definition of Patient Safety by NQF:

- Freedom from injury or illness resulting from the processes of care
- Patient safety event is an occurrence or potential occurrence, that is directly linked to the delivery of healthcare that results, or could result, in injury, death, or illness
Other Words for Medical Errors

- Adverse event, adverse outcome, adverse drug event, unanticipated outcome
- Sentinel event (TJC)
- Iatrogenic injury
- Hospital acquired complication, medical mishap, therapeutic misadventure
- Medical error or mistake
- Glitches or peri-therapeutic accident
- Unplanned clinical occurrence or unintended consequences

Patient Safety Studies

- Many studies showed that a large percentage of the errors that occur in healthcare are due to system error
- They are not due because of the negligence of a staff member or physician
- It is not a blame and train mentality
- Studies found that healthcare facilities needed a non-punitive environment
- A healthcare facility can not fix a problem it does not know exists
Patient Safety

- Having a non-punitive environment would encourage reporting of errors and near misses.
- Both the Joint Commission (TJC) and the Centers for Medicare and Medicaid Services (CMS) require a non-punitive environment.
- However, many healthcare facilities have balanced this with the Just Culture theory or model.
- A person who is reckless or does something intentional to harm a patient should be terminated from employment.

AHRQ Definition of Just Culture

- Just Culture refers to a safety-supportive system of shared accountability in which health care institutions are accountable for the practices they have designed and for sustaining the safe choices they have made regarding patients, visitors, and staff.
- Staff are accountable for the quality of the choices they make to ensure patients receive the highest quality of care.
- See AHRQ Comprehensive Unit-Based Safety Program (CUSP) toolkit.
Patient Safety and Just Culture

- The studies show that individual blame is still dominant despite the literature
- No blame is the appropriate stance for system related errors
- But what about reckless behavior or intentional acts that lead to harm
- Certain errors do demand accountability and the Just Culture theory is that balance
- Without accountability we will never achieve optimal outcomes

Patient Safety and Just Culture

- In a totally blame free culture, there is a failure to follow standards of care
  - Staff less likely to hold one another accountable
- In contrast, just culture will support improved outcomes by emphasizing both appropriate behaviors and robust systems
- Establishes zero tolerance for reckless behavior such as ignoring all of the safety steps put in place
- Just culture principles enhance culture, accountability and safety in the hospital
Just Culture

- Just Culture recognizes the difference between **human error** (such as slips), **at-risk behavior** (such as taking shortcuts), and **reckless behavior** (such as ignoring required safety steps like bar coding and having second person double check high risk drugs), in contrast to an over reaching "no-blame" approach.

- It is important to note that the response is not based on the severity of the event or if it caused harm.
  - It is about the quality of the behavioral choice.

- Reckless behavior such as refusing to do a time out would merit punitive action even if the patient was not harmed.

Just Culture

- You want to create a open, fair and just culture
  - Staff feel comfortable to report and discuss errors.

- You want to create a learning culture
  - We need to learn from our mistakes and make sure staff are aware of what happens at our facility.

- You want to create safe systems
  - Time outs, bar coding coupled with an eMAR, double check of high alert medications, do not work nurse over 60 hours a week to prevent fatigue etc.

- You want to manage behavioral choices.
Just Culture Journey

- AHRQ defines just culture as one in which frontline staff feel comfortable in disclosing errors including their own while maintaining professional accountability.
- Definitions and descriptions of just culture vary widely as does hospital execution and implementation practices.
- It is important to preserve an appropriate balance of accountability.
- Peter Pronovost MD and Robert Wachter MD, Oct 2009 JAMA article talk about accountability.

Just Culture and Accountability

- Once hospitals have a reliable system in place they do need the threat of sanctions to ensure that everyone follows the rules.
- They propose suspending privileges if physicians fail to practice hand hygiene or refuse to take a time out.
- This carefully discriminates between system issues and individual violations of safety policies.
- Strong leadership is needed to ensure this.
  - Need to find out if system issue or not so good people don’t make mistakes and want learning environment.
Many facilities balance Just Culture Theory with taking a non-punitive approach to all errors

- Question is what system of accountability best supports system safety?
- Recognizes that error is rarely the fault of a single individual

If you get the opportunity listen to the presentation by David Marx who is president of Outcomes Engineering, LLC

- James Reason, Sidney Dekker and others have contributed to the advancement of just culture

Human factor design to reduce the rate of error

- When cardioverting the machine automatically reverts to defib and the patient died so let’s redesign the machine
- Redundancy to limit the effects of failure (mistake proofing)
- Balance duty against organizational and individual values

There are three duties

- Duty to avoid causing unjustified risk or harm
- Duty to produce an outcome
- Duty to follow a procedural rules
Just Culture Principles

- Values and expectations- what is important to the organization
- System design- continual redesign of system and address processes and systems so it does not happen to someone else
  - Humans are fallible and make mistakes through inadvertent errors or it can be from risky behavior
  - Coaching and open environment
  - We need systems to minimize risk
  - Forcing functions, checks and redundancies to minimize risk

Just Culture Principles

- Outcomes- make sure rate of adverse events is headed in the right direction and have good outcomes
- Open reporting is willingness to report near misses and adverse events
  - Want an environment where there is no fear to report things
  - Search for causes beyond who made the error and prevent drifting toward at risk behaviors, do RCA on what went wrong
- Internal transparency- willingness to talk in the organization about the risks and errors- discuss with patients openly
Just Culture Principles

- Behavioral choices
  - Managing human behavior is essential to improving outcomes
  - We need to reinforce good behaviors that reduce risk and deter bad behavior that increases risk
- Patient safety and error reporting is encouraged
- Peer to peer coaching where helping one another to stay safe and make sure things are being done correctly
- Just culture algorithms can help
Just Culture Principles

- Responses to human error- willing to discuss this and discipline does not help if one makes a mistake
- Responses to reckless behavior- take action if reckless behavior to one who knowingly endangers a patient- need to be fair culture
- Severity bias in rejection of no harm no foul, it is not based on only looking at issue if patient was harmed
- Equity is about being fair and consistent with every employee group and all are set for the same expectations

Just Culture Accountability

- Human errors- slips, lapse or mistakes
  - Manage through processes, procedures, training and design-CONSOLE
- At-Risk Behavior- a choice-risk not recognized or believed justified, behaving in a way that increases risk
  - Manage through removing incentives for at risk behavior and creating incentives for healthy behaviors and increasing situation awareness-COACH
- Reckless Behavior-conscious disregard of unreasonable risk
  - Manage through remedial action or punitive action-PUNISH
Managing Error and Risk

Human Error
Product of our current system design and behavioral choices
Manage through changes in:
- Choices
- Processes
- Procedures
- Training
- Design
- Environment

At-Risk Behavior
A choice: risk believed insignificant or justified
Manage through:
- Removal of incentives for at-risk behaviors
- Creation of incentives for healthy behaviors
- Situational awareness

Reckless Behavior
Conscious disregard of substantial and unjustifiable risk
Manage through:
- Remedial action
- Punitive action

Just Culture Video

Understand Just Culture (Audio/Video Item)

The CUSP toolkit includes training tools to make care safer by improving the foundation of how your physicians, nurses, and other clinical team members work together.

These videos reinforce the material presented in each module of the CUSP toolkit.

Culture Size: 1 minute 52 seconds
Just Culture Policy

POLICIES AND PROCEDURES

SUBJECT: SAFE AND JUST CULTURE

POLICY NO: 311.4

PURPOSE:
To define a Safe and Just Organizational Culture within the Department of Health Services (DHS).

SCOPE:
All DHS workforce members, which includes employees, contract staff, affiliates, volunteers, trainees, students, and any other persons whose conduct, in the performance of work for DHS, is under its direct control, whether or not they receive compensation from the County.

PHILOSOPHY:
DHS strives to build, maintain, and support a Safe and Just Culture. A Safe and Just Culture is one in which safety is an individual and organizational priority and where errors, near misses, and adverse events can be easily reported and are viewed as an opportunity to learn and improve upon the delivery of care. Reporting will not be impeded by the fear of discipline or retaliation.

The healthcare environment, in all of its aspects, is one in which the occurrence of error is recognized as inevitable, often as a result of flawed systems. A Safe and Just Culture supports the identification and improvement of these flawed systems.

POLICY:
DHS leadership supports the implementation of a Safe and Just Culture, consistent with The Joint Commission Leadership Standards. Individuals will be accountable for their own performance in accordance with their job responsibilities and DHS core values. However, individuals will not carry the burden for system flaws over which they have no control.

Safety Culture

- The concept of safety culture started in areas outside of healthcare such as the airline industry
- The studies look at high reliability organizations
- These are organizations that were complex and hazardous yet they were able to minimize adverse events
- These organizations maintained a commitment to safety at every level
- The hospital must have organizational commitment to establish a culture of safety
Safety Culture

- Hospitals need to be proactive to prevent harm from occurring instead of being reactive and doing something once a patient is harmed
- Patient safety needs to be viewed as a strategic priority
- The entire hospital needs to be focused on patient safety if a culture of safety is to be established
- A safe culture is evidenced by employees who are guided by the organizational commitment and where safety standards are upheld on a personal and team level

Key Features of a Culture of Safety AHRQ

- Acknowledgment of the high-risk nature of an hospital’s activities and the determination to achieve consistently safe operations
- A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
- Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- Organizational commitment and resources to address safety concerns
Safety of Culture

- There needs to be visibility among senior leaders to front line staff
  - How many hospitals leaders do patient safety rounds or walkabouts?
  - Strategic planning of patient safety is important
- There needs to be greater education of physicians about safety efforts
  - Many physicians did not report adverse events

Safety Initiatives

- Hospital in the study had a patient safety committee
- This committee created a safety mission statement
- Developed a non-punitive error reporting policy
- Created information sheet of safety tips for patients and families
- Educated staff on the science of safety and how to disclose errors
- Developed a safety intranet site to share stories on patient safety
- Implemented senior safety walkabouts
Measuring a Culture of Safety

- Generally it is measured by doing a survey of staff at all levels
- Validated surveys include AHRQ patient safety culture surveys and safety attitudes questionnaire
  - Culture Survey at http://www.ahrq.gov/qual/patientsafetyculture/
- TJC requires accredited hospitals to do a safety culture survey
- The NQF 34 Safe Practices for Better Healthcare recommend this be done on an annual basis
Surveys on Patient Safety Culture

As part of its goal to support a culture of patient safety and quality improvement in the Nation’s health care system, the Agency for Healthcare Research and Quality (AHRQ) sponsored the development of patient safety culture assessment tools for hospitals, nursing homes, and ambulatory outpatient medical offices.

Three surveys on patient safety culture are available:

- Hospital Survey on Patient Safety Culture
- Medical Office Survey on Patient Safety Culture
- Nursing Home Survey on Patient Safety Culture

Health care organizations can use these survey assessment tools for:

Hospital Survey on Patient Safety Culture

In 2004, the Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture, a staff survey designed to help hospitals assess the culture of safety in their institutions. Since then, hundreds of hospitals across the U.S. and internationally have implemented the survey.

In response to requests from hospitals interested in comparing their safety culture survey results to other hospitals, AHRQ funded the development of a comparative database on the survey in 2004. The database is comprised of voluntarily submitted data from U.S. hospitals that administered the survey. Comparative database reports were produced in 2007, 2008, 2009, and 2010, and will be produced semi-annually through at least 2012.

Hospital Survey Toolkit | Comparative Database | Data Entry and Analysis Tool | Hospital Patient Safety Improvement Resources | International Users | Technical Assistance

Hospital Survey Toolkit

Frequently Asked Questions

Survey Form

- Hospital Survey—English (PDF Version, 178 KB) (PDF Help, Word Version, 159 KB)
- Facility version—For hospitals and ambulatory and sub-acute facilities (PDF Version, 205 KB) (PDF Help, Word Version, 155 KB)
- Hospital Survey—Spanish (PDF Version, 230 KB) (PDF Help, Word Version, 122 KB)

Survey Items and Dimensions

- Hospital Survey Items and Dimensions—English (PDF Version, 75 KB) (PDF Help, Word Version, 50 KB)
- Hospital Survey Items and Dimensions—Spanish (PDF Version, 246 KB) (PDF Help, Word Version, 95 KB)

Survey User’s Guide

The User’s Guide provides a general overview of the issues and major decisions involved in conducting a survey and reporting the results. This Guide includes information on putting the survey together, selecting a sample, determining data collection methods, establishing data collection procedures, conducting a Web-based survey, and preparing and analyzing data, and producing reports.
Hospital Survey on Patient Safety

Instructions

This survey seeks your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

- An "event" is defined as any type of error, mistake, incident, accident, or abduction, regardless of whether or not it results in patient harm.
- "Patient safety" is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend most of your work time or provide care of your clinical services.

What is your primary work area or unit in this hospital? Select ONE answer.

- a. Every different hospital unit is a specific unit
- b. Medicine (e.g., surgery)        c. Psychiatry/mental health
- d. Pediatrics
- e. Obstetrics
- f. Alcoholism
- g. Other, please specify: ____________________________________________

Please indicate your agreement or disagreement with the following statements about your work area/unit.

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<thead>
<tr>
<th>Think about your hospital work area/unit...</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td>1. We are actively doing things to improve patient safety ...........................................</td>
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<td>2. We use a method of temporary staff to best patient care ........................................</td>
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<td>3. Staff feel like their mistakes are held against them ..............................................</td>
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<td>4. Mistakes have led to positive changes here ............................................................</td>
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<td>5. It is just by chance that more serious mistakes don't happen around here ..................</td>
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<td>6. When one area in the unit gets really busy, others help out .....................................</td>
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<td>7. When an event is reported, it feels like the person is being written up, not the problem</td>
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<td>8. After we make changes to improve patient safety, we evaluate their effectiveness ..........</td>
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<td>9. We work with teams to try to do as much, too quickly .............................................</td>
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<td>10. Patient safety is never emphasized to get more work done ........................................</td>
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<td>11. Staff worry that mistakes they make are kept in their personal file ..........................</td>
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<td>12. We have patient safety problems in this unit .........................................................</td>
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<td>13. Our procedures and systems are good at preventing errors from happening ..................</td>
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SECTION B: Your Supervisor/Manager

Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager.
10 Dimensions of Safety

- Supervising/manager expectations and actions promoting patient safety (supervisor says a good word when sees job done to establish patient safety, supervisor considers staff suggestions)

- Organizational learning-continuous improvement (actively doing things to improve safety, mistakes lead to positive change, evaluate effectiveness after changes made)

- Teamwork within units (people support one another on the unit, work as a team to get things done, treat each other with respect)

- Communication openness (staff feel free to speak up if something could negatively impact patient care, feel free to question decision of those with more authority)

- Feedback and communication about error (given feedback about changes put into place based on events, informed about errors that happen on this unit and discuss ways to prevent from happening again)

- Non-punitive response to error (staff feels mistakes not held against them, not kept in personnel file, understand person who made mistake in not the problem)
10 Dimensions of Safety

- Staffing (enough staff to handle work load)
- Hospital management support for patient safety (management promotes client that promotes patient safety, patient safety is top priority, patient safety an issue not only after adverse event)
- Teamwork across hospital units (good cooperation among hospital units, unit work together, other units pleasant to work with)
- Hospital handoffs and transitions (things don’t fall between the cracks when transferring patient to another unit, important care information not lost during report, shift change not problematic for patients)
Safety Attitudes Questionnaire

The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research

Abstract

Patient safety culture can be measured

Hospitals with poor safety culture have more medical errors

Improvements in patient safety culture has been achieved by specific measures such as;

- Teamwork training
- Executive walk rounds
- Unit-based safety teams (CUSP)
- RRT, SBAR and other structured communication methods are unproven but being used to improve communication
System Analysis Theory

- One of the original articles involved System Analysis of Adverse Drug Events which was published in the July 1995 edition of JAMA
  - Found 16 underlying themes of system problems
  - Found 22% of errors were due to lack of drug knowledge of ordering physician
    - How can one humanly remember 10,000 drugs so recommend use of a PDA or other tool
  - 7 system failures resulted in 78% of the problems and this was distinct from individual provider error
    - Correlated to the MedMarx studies

Systems Approach

- The authors advocate a non-punitive systems approach as a more effective means of preventing error than approaches focused on the individual
- Traditionally medicine has treated errors as failing on the part of the individual
- The systems approach takes the view that most errors reflect predictable human failings in the context of poorly designed systems (eg, expected lapses in human vigilance in the face of long work hours or predictable mistakes on the part of relatively inexperienced personnel faced with cognitively complex situations).
Systems Approach

- Rather than reprimanding individuals or pursue remedial education the system approach identifies situations or factors likely to give rise to human error
- And implement "systems changes" that will reduce their occurrence or minimize their impact on patients
- This view holds that efforts to catch human errors before they occur or block them from causing harm will ultimately be more fruitful than ones that seek to somehow create flawless providers

Systems Approach

- The system focus includes paying attention to;
  - Human factor engineering
- Relevant concepts in the systems approach includes
  - Root cause analysis (RCA)
  - Active vs latent conditions
  - Errors at the sharp end vs the blunt end
  - Slips vs mistakes and
  - The Swiss cheese model
Patient Safety Outcomes QuIC

- Look at the results of the safety survey as a determination of patient safety outcomes
- Hospital survey on patient safety culture was sponsored by QuIC (The Quality Interagency Coordination Task Force)
- Initially set up to ensure that federal agencies that provide or regulate health care services worked in a coordinated way
- QuIC’s had 4 overall patient safety outcomes
- QuIC website is http://www.quic.gov/

Patient Safety Outcomes

- Overall perception of safety (are procedures and systems good to prevent errors, patient safety never sacrificed to get more work done)
- Number of event reported (in past 12 months, how many events reports were filled out)
- Frequency of events reported (when error is made is it reported and are near misses reported) and
- Overall patient safety grade (would rate hospital on overall patient safety grade)
Human Factors

- Human factors (HF) is the study of how people use technology. It involves the interaction of human abilities, expectations, and limitations, with work environments and system design, (safer connections, easier to use devices, easier to read controls and displays).

- The term “human factors engineering” (HFE) refers to the application of human factors principles to the design of devices and systems. It is often interchanged with the terms "human engineering," "usability engineering," or "ergonomics." (man-machine interface)

Reason’s Model of Safety

- Numerous studies show impact of human error on patient safety

- Famous Harvard Medical Practice Study- 69% of injuries were caused by human error

- Reason classified errors as either active failures or latent conditions

- Could you use this information to design a new hospital?
Active Failures

- Term as applied to errors coined by James Reason
- Are those errors made by those who provide direct care to the patient such as nurses and physicians
- Active errors occur at the point of contact between a human and some aspect of a larger system (human-machine interface)
- Like ignoring a warning light or pushing an incorrect button
- Active failures are difficult to predict

Active Failures or the Sharp End

- Active failures sometimes referred to as the “sharp end”
- Errors that happen at the sharp end are noticed first because they are committed by the person closest to the patient
- Nurse giving wrong dose of heparin to 6 babies
- Another example is programming the IV pump incorrectly
Latent Failures or the Blunt End

- Those conditions which are present in the healthcare system and are less apparent
- The facility, equipment, and processes that contribute with the active failures to produce error or allowed them to happen
- Latent failures arise because of lack of standardization of equipment and processes
- Poor visibility, high noise levels and excessive movement of patients
- Latent errors are also referred to as the “blunt end”

Latent Errors

- It is all the many layers of the healthcare system that affect the person holding the scalpel
- These are the less apparent failures of the organizational design that contribute to the error and allowed it to happen
- Pharmacy tech put wrong heparin in machine, pharmacist failed to catch it, look alike of labels, no bar coding technology etc.
Latent Errors

- Lack of computer warnings
- Ambiguous drug references
- Unclear policies and procedures
- Incomplete patient information such as missing allergy information or diagnosis
- Can be remedied with safety barriers before they contribute to an adverse event
- In systems approach, error reduction is obtained by building barriers and safeguards into equipment and technology and processes

Human Error

- Leape, Reason, and Norman inform us that human error attributable to;
- Human cognition and limitation of memory
  - Can I really remember the side effects of every drug?
  - Do I need a check off sheet before that patient goes to surgery?
- Checklist for performing central line insertion
- Slips, mistakes, or relapses occur for many reasons,
Human Error

- Distractions
  - Nurse interrupted 19 times trying to pass medications
- Multitasking or deviation from routine activity
- Knowledge based thought process that borrows from past experience
  - The last place I worked the orange bracelets meant DNR not a high fall risk

Creating a New Hospital

- Hospital put together a learning lab
- Top recommendations from learning lab
- Design FMEA at each design stage
- Standardize location of equipment, supplies, room layout and care processes
- Use checklist for current/future design
- Reduced noise
  - Creating a Culture of Patient Safety through Innovative Hospital Design, John Reiling at http://www.ahrq.gov/qual/psresearch.pdf,
Culture of Safety

- In designing new hospitals looked at culture of safety
- James Reason defines culture as “shared values” (which is important)
- and beliefs (how things really work) that interact with an organization’s structure and control systems
- to produce behavioral norms (the way we do things around here)

Multi-Causal Theory “Swiss Cheese” diagram (Reason, 1991)
Components of Safety Culture

- Reason’s components of safety culture include **informed culture** (those who manage and operate the system have current knowledge about the factors that determine the safety of the system)
- Reporting culture (people are prepared to report their errors and near misses)
- Just culture (people are encouraged and even rewarded for providing safety related information but must be clear about what is acceptable and unacceptable behavior)

Components of Safety Culture

- Learning culture
  - Willingness and know-how to draw the right conclusion from a safety information system
  - And how to implement reforms
- Safety culture can be engineered
Developing a Culture of Safety

- Instituted blame free reporting
- Open discussion of human conditions
- Executive walk arounds
- **Story telling** especially about incidences within the organization
- Confidential and anonymous reporting process

Noise is a Latent Condition

- WHO found noise is serious health hazard and threat to patient safety
- Affects performance and concentration
- Contributes to stress
- Effects patients—elevates BP, increases pain, alters quality of sleep, and reduces overall patient satisfaction
- Hospital used carpeting, absorbent ceiling tile, stronger steel, quiet engineered mechanical systems and eliminated overhead paging
Standardization-latent condition

- Investigated in commercial aviation
- Little research on how it can prevent medical errors in healthcare
- **Standardization** has been documented in human factors design
- Reduces reliance on short term memory and allows those unfamiliar with given process to use it
- New hospital built and all the units are designed to be identical

Standardization

- Much of work in human factors focuses on improving human system interface by designing better systems and processes
- From location of outlets, bed controls
- Cupboards in which gloves and supplies are stored
- Standardize units such as ED, PACU, ambulatory
- Equipment such as IV pumps, IVs, monitors, medication and decision support systems
- Defibrillators designed to work the same way and can not defib by mistake if mean to cardiovert
Infections

- New hospital designed with infection control in mind
- Put sinks in all rooms with video camera on sink to measure hand hygiene rate
- Wash their hands or use hand hygiene in front of the patient
- Used HEPA filters in public areas
- Used ultraviolet lights in key patient care areas to eliminate pathogens
- Single patient rooms
- Modified laminar flow – air flow in patient rooms

Component of Culture of Safety

- Commitment to highest level of shared values and beliefs (board and administration)
- Necessary resources, incentives, and rewards to allow commitment to occur
- Safety is valued as primary priority
- Communication is candid and frequent between staff and administration
- Work as a team
Component of Culture of Safety

- Obligation to listen when others have a concern
  - Consider using a safe word such as “can you clarify for me”
- Ability to speak up and raise concerns
  - 40% of staff did not speak up when they knew there was a medication error
- Use of the systems analysis approach which looks at the process and how it leads to error as opposed to the focusing on individual blame
- Error reporting and disclosure of error are two important concepts

Safety Design

- We must break free of the blame and train mentality
- Staff will never voluntarily report unless system is changed
- Most errors made by long term employees with unblemished records
- We must change the system that leads to errors
- Example is hospital has three types of IV pumps and nurse is using a new one in which she has not been trained and patient dies after pump is programmed wrong
Reliability

- **Reliability theory** is the method of evaluating, calculating, and improving the overall reliability of a complex system.
- Used by airline, nuclear power and manufacturing.
- IOM report states healthcare can benefit from application of reliability principles.
- RAND study found only 50% of patients get care consistent with evidenced based literature.

High Reliability Theory

- In reliable healthcare system every patient would get evidence based effective care every time they needed it.
- No variation in the kind or quality of care due to the time or place of care or gender or socio-economic status.
- IHI has many resources on High Reliability Organizations at [www.ihi.org](http://www.ihi.org).
- Abbreviated HRO.
Reliability

3 step model for applying to hospitals and healthcare;

- **Prevent failure** (a breakdown in operations or functions, look at uniform guidelines, checklists, basic standardizations, awareness raising and training)

- **Identify and Mitigate failure** (identify and fix before it causes harm, called error proofing)

Reliability

- **Redesign** is the third model for designing high reliability organizations
  - The process based on the critical failures is identified
    - Identify failure modes-what are the weaknesses that can lead to failure-FMEA
The Conditions of Participation (CoPs)

- All hospitals that receive payment for Medicare or Medicaid patients have to follow the CoP and for all patients
- Current CoP is dated February 14, 2014
- Many updates to manual since it came out in 1986: visitation, telemedicine, IV medication, blood, pharmacy, privacy & confidentiality, report AE to PI program, Luer Misconnections, Insulin pens, safe injection practices, three worksheets, common findings in complaint surveys, rehab and respiratory changes

The Hospital CoPs

- First, CMS publishes the regulation in the Federal Register ¹
  - Anyone can sign up to get it sent to their computer at no charge
- Second, CMS then publishes Interpretive Guidelines so the hospitals and surveyors will understand how they are interpreting it ²
- Third, CMS sometimes has Survey Procedure which directs the surveyor what documents to look at or what questions to ask

5/14/2014

CMS Hospital CoPs

- All Interpretative guidelines under the state operations manual (SOM)
  - Appendix A, Tag A-0001 to A-1164 and 456 pages long
- Manuals
  - Manuals are now being updated more frequently
  - Good place to keep up on new changes is the survey and certification website1 and transmittals2

1 www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp
2 http://www.cms.gov/Transmittals/01_overview.asp

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Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

New website at

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<tr>
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<td>Psychiatric Hospitals</td>
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Mandatory Compliance

- Hospitals that participate in Medicare or Medicaid must meet the COPs for all patients in the facilities
  - Not just those patients who are Medicare or Medicaid
- Hospitals accredited by TJC, AOA, CIHQ, or DNV Healthcare have what is called deemed status
- This means you can get reimbursed without going through a state agency survey
- Can still get complaint or validation survey
- CAH have a separate manual under Appendix W

CMS Hospital CoP

- CMS states that the hospital must have a voluntary, non-punitive, reporting system to monitor and report adverse drug events
  - Including medication errors and adverse drug reactions
  - Tag number A-0490
- CMS says to improve incident reporting the facility should adopt a non-punitive system with the focus on the system and not the involved health care professionals
  - Tag number 508
**CMS Hospital CoP Tag A-0508**

- Reduction of medical errors and adverse reaction can be achieved by effective reporting systems that proactively identify causative factors
  - FMEA is a proactive tool and incident reporting system
  - And are used to implement corrective actions to reduce or prevent reoccurrences
  - RCA can be used to identify corrective actions
- Must adopt a definition of medication error and ADR that is broad enough to include near misses (close call) and suspected ADR

**CMS Survey Procedure Tag 508**

- Determine that the hospital has an effective procedure that ensures drug administration errors, adverse drug reactions, and drug incompatibilities are immediately reported to the attending physician.
- Review records of medication errors and adverse drug reactions to determine that they are reported immediately in accordance with written procedures, and that medications administered and/or drug reactions are promptly recorded in the patient’s medical record.
CMS Survey Procedure Tag 508

- Is the facility’s **definition** of an adverse drug reaction and medication error based on established benchmarks or studies on report rates published in peer-review journals?

- Is it identifying as many medication errors and adverse drug reactions as would be expected for the size and scope of services provided by the hospital?

- Will make sure staff called the doctor if medication error or suspected ADR.

TJC LD Patient Safety Program


- This standard includes the **patient safety program requirements**

- The standard is LD.04.04.05

- This standard has 14 elements of performance

- It also included the requirements for FMEA and RCA
LD: The hospital implements an integrated patient safety program throughout the hospital

This is the section that requires leaders to develop a hospital wide safety program

Must proactively explore potential system failures

Must encourage reporting of AE and near misses (good catches)

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EP1. There is a hospital-wide, integrated patient safety program.

EP2. One or more qualified individuals or an interdisciplinary group manages the hospital-wide safety program.

EP3. The scope of the program includes the full range of safety issues, from potential or no-harm error (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events, which have serious adverse outcomes.
Operations  Patient Safety Program

- EP4. All departments, programs, and services within the hospital participate in the safety program.
- EP5. The hospital creates procedures for responding to system or process failures, such as continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

Patient Safety Program

- EP6. The hospital defines responses to various types of potential AE. There needs to be a system approach for blame free reporting of a system or process failure. This also included the results of the proactive risk assessment (FMEA),
- EP7. The hospital defines a sentinel event. This needs to be communicated throughout the hospital.
  - EC.02.01.0, EP1. This is the standard that requires the hospital to manage safety and security risks.
  - Note TJC has a sentinel event policy and process on their website at www.jointcommission.org
## Operations  TJC Patient Safety Program

- EP8 A through and credible RCA must be done when there is a sentinel event as described in SE chapter
- EP9. The hospital has support systems available for staff members who have been involved in a sentinel event (SE) or adverse event
- Good employees who make mistakes are victims too
- Provide employee assistance programs or counseling

## Operations  TJC Patient Safety Program

- EP10. The hospital selects one high risk process and conducts a proactive risk assessment at least every 18 months
- EP11 The hospital uses information about system or process failures and the results of the proactive risk assessment to improve patient safety
- EP12. The hospital disseminates lessons learned from RCA, system or process failures, and the results of the FMEA to staff that provide services or are affected by the situation
Operations  TJC Patient Safety Program

- EP13. The hospital provides governance at least once a year, with written reports on all system or process failures, on the number and type of SE, on whether the patients and the families were informed of the AEs, and on all actions taken to improve safety, both proactively and in response to actual occurrences.

- EP14. The hospital encourages external reporting of significant adverse events, including voluntary reporting programs (TJC SE and FDA MedWatch) in addition to mandatory programs (some states have mandatory reporting and some require reporting of NQF never events).

Examples of Compliance

- Have a patient safety plan
- Do an annual report card, use trigger tools
- Have a patient safety committee
- Many also have separate medication management committee and EOC safety committee
- Do education for staff to make sure they know near misses must be included in definition of medical error
- Do patient safety walkabout rounds by senior leaders
Examples of Compliance

- Ensure MS participation in patient safety
- Board minutes should document safety reports
- Have department safety department champion
- Provide literature and articles on patient safety on intranet
- Consider patient safety week fair with local articles in newspaper and patient safety literature
- Board report at least yearly, consider more frequent, written reports of sentinel events, and whether patient informed

Examples of Compliance

- Have one person in charge of internal and external reporting of system failures (required reports, voluntary reports)
- Have a user friendly RCA and FMEA form
- Consider training many on this process
- Do more than just one FMEA a year but know why you picked them (transfusion, infant abduction, medication error, inpatient suicide)
- Disseminate information in memo and newsletter rea lessons learned RCA
**NQF 34 SAFE PRACTICES**

- Released in 2003, updated 2006, 2009 and April 2010
- These should be followed in all healthcare facilities
  - All clinical care settings to reduce risk of harm to patients
  - A roadmap to preventing harm
- States 10 years after IOM report, To Err Is Human, uniformly reliably safety in healthcare has not been achieved

**Patient Safety Handbook for Nurses**

- AHRQ has a free evidenced based handbook for nurses
- Dove tails NGF 34 Safe Practices well
- 1,400 pages and 51 separate chapters
- Can print off, order the 3 volume set, or a CD
- Includes chapters on many great topics such as defining patient safety, staffing, medications errors, patient centered care, falls, patient safety opportunities, handoffs, disclosure, communication, HAI, wrong site surgery, etc.,
  - At http://www.ahrq.gov/qual/nurseshdbk/
AHRQ and Dept of HHS have published common formats for collecting and reporting patient safety information, working with NQF.

- Formats authorized by Patient Safety and Quality Improvement Act of 2005 (PSO)
- Resource contains common definitions
- Includes reporting format for facilities to collect and track patient safety information in same manner
Did You Know?

- Preventable medical errors are actually on the rise by 1% per year
- There are about 1.7 million HAIs and 99,000 deaths a year
- There are at least 1.5 million preventable drug events each year due to drug mix ups and unintentional over doses
- 18 types of medical errors account for 2.4 million extra hospital days and $9.3 billion in excess care

Did You Know?

- One in five patients discharged from the hospital end up sicker within 30 days and half are medication related.
- One of 10 inpatients suffers as a result of a mistake with medications cause significant injury or death.
- Preventable medical errors cost the US $17 to $29 billion dollars a year.


Safe Practices

- 34 Safe Practices
- Organized into 7 functional categories
- Leaders and boards are called upon to proactively review the safety of their organization and to take action to improve safety.
- Detailed bib list in book at end
- Also has list of 29 never events or serious reportable errors that many states require to be reported.
How to Order the Book

- Can be ordered at National Quality Forum at www.qualityforum.org
- No cost for members
- Non-member copy is $29.99 to download off website
- Print copy is $89.99
- Safe Practice for Better Healthcare-2010 Update: A Consensus Report
- Call 202 783-1300
1. Leadership Structures and Systems

- Leadership structures and systems must be established to ensure that there is organization-wide awareness of patient safety performance gaps,
- Direct accountability of leaders for those gaps,
- Adequate investment in performance improvement abilities,
- Actions must be taken to ensure safe care of every patient served.

Leadership Structures and Systems

- **Do you have a patient safety program?**
  - Is there education on patient safety and patient safety plan?
  - Just culture where frontline staff are comfortable disclosing errors but still maintains accountability
- **Is there a patient safety officer?**
  - Who coordinates patient safety education?
  - With direct and regular communication with board and senior leaders?
  - Senior leaders and department directors are accountable to close performance gaps
1. Leadership Structures and Systems

- Is there an interdisciplinary patient safety committee?
  - Do leaders support the committee?
  - Board and leaders help set patient safety goals
  - Oversee RCA and feedback to frontline workers
  - Provides training in teamwork techniques

- Direct organization-wide leadership accountability

- Board briefed in results of culture survey and activities to identify and mitigate risks
  - Every board meeting should include patient safety issues

1. Leadership Structures and Systems

- Direct patient input on formal committees on safety and not just patient satisfaction surveys

- Board and senior leadership should regularly assess budgets for patient safety, people systems (staffing), PI, and technology that impact safety

- Board members should be trained in team work (discussed later) and patient safety
  - Board should be competent in patient safety and do an annual assessment and ensure new board members well versed in patient safety
1. Leadership Structures and Systems

- Board and senior LD and CEO need to establish systems to ensure medical leaders have input into safety programs

- CEO and senior leadership should design certain **amount of time for patient safety activities**
  - **Teamwork training**
  - Take actions to identify and mitigate risks and hazards (discussed in detail later)
  - Regular patient safety related session at meetings
  - Weekly walk-rounds
Patient Safety Walk Abouts

- Also called leadership walk rounds or executive walk rounds
- AHA has easy to use manual developed in conjunction with 3 year pilot program in 10 hospitals
- 200 hospitals used thru IHI collaboration
- Research shows positive effect on safety culture attitudes of nurses and improves safety culture

AHA Opening Statement

We are moving as an organization to open communication and a blame-free environment because we believe that by doing so we can make your work environment safer for you and your patients. The discussion we are interested in having with you is confidential and purely for patient safety and improvement.

We are interested in focusing on the systems you work in each day rather than on blaming specific individuals. The questions we might ask you will tend to be general ones, and you might consider how these questions might apply in your work areas in regards medication errors, communication or teamwork problems, distractions, inefficiencies, problems with protocols etc.
AHA Opening Statement

- We are happy to discuss any issues of concern to you. Our goal is to take what we learn in these conversations and use them to improve your work environment and the overall delivery of care.”

Questions Asked in Walk Rounds

- Have there been any near misses that almost caused patient harm today?
- Have we harmed any patients recently?
- What aspects of the environment are likely to lead to harm?
- Is there anything we could do to prevent the next adverse event?
Questions Asked in Walk Rounds

- Can you think of any events in the past days which have resulted in prolonged hospitalization for a patient?
- Can you think of a way in which the system or your environment fails you on a continual basis?
- Would specific interventions from leadership could make your work safer?
- What would make this executive walkabout more effective?
2. Culture Measurement, Feedback, & Intervention

- Hospitals must measure their culture,
- Provide feedback to the leadership and staff,
- Hospitals must undertake interventions that will reduce patient safety risk
10 Patient Safety Tips for Hospitals

- AHRQ publishes the 10 Patient Safety Tips for Hospitals
- Prevent central-line associated bloodstream infection
  - Some hospitals report zero infections
  - IHI How to tool kit and also TJC NPSG
- Hospitals will have to benchmark for report card using CDC HHSN or National Healthcare Safety Network at http://www.cdc.gov/nhsn/
- APIC has "I Believe in Zero CLABSIs" at www.apic.org
- AHRQ resources at http://www.ahrq.gov/qual/hais.htm

Medical errors may occur in different health care settings, and those that happen in hospitals can have serious consequences. The Agency for Healthcare Research and Quality (AHRQ), which has sponsored hundreds of patient safety research and implementation projects, offers these 10 evidence-based tips to prevent adverse events from occurring in your hospital. Ordering information and links to free AHRQ tools are also provided.

1. Prevent central-line associated bloodstream infections. Be vigilant preventing central-line associated bloodstream infections by taking five steps every time a central venous catheter is inserted: wash your hands, use full-barrier precautions, clean the skin with chlorhexidine, avoid femoral lines, and remove unnecessary lines. Taking these steps consistently reduced this type of deadly health care-associated infection to zero in a study of more than
10 Patient Safety Tips for Hospitals

- Re-engineer hospital discharges
  - Hospitals that have higher than normal readmissions will be financially penalized in 2013
  - AHA has a 2010 guide to prevent readmissions
  - 20% of patients discharged have an adverse event within 3 weeks

- Prevent venous thromboembolism
  - Eliminate by using evidence based guidelines
  - Many free toolkits are available
  - Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement is available at http://www.ahrq.gov/qual/vtguide/

- Educate patients about blood thinner safety
  - AHRQ has resource on how to use safely at http://www.ahrq.gov/consumer/btpills.htm
  - Includes 10 minute patient educational video and 24 page booklet

- Limit shift durations for medical residents and other staff if possible
  - Fatigued staff make more mistakes
  - Residents who 30-hour shifts should only treat patients for up to 16 hours and should have a 5-hour protected sleep period between 10 p.m. and 8 a.m
10 Patient Safety Tips for Hospitals

- Consider working with a PSO
  - Patient safety organizations can help avoid preventable error
  - Information at http://www.pso.ahrq.gov/

- Use good hospital design principles
  - Well designed bathroom with big doors and close to patient bed and single rooms can prevent patient falls
  - Has video on Designing for Safety at http://www.ahrq.gov/qual/transform.htm
  - Creating decentralized nursing stations

- Measure your hospital’s patient safety culture
  - AHRQ has hospital survey toolkit

- Build better teams and rapid response systems
  - TeamSTEPPES toolkit is available to help team building at http://teamstepps.ahrq.gov/index.htm

- Insert chest tubes carefully
  - Remember UWET when inserting chest tubes
  - Universal Precautions (achieved by using sterile cap, mask, gown, and gloves); Wider skin prep; Extensive draping; and Tray positioning
  - http://www.ahrq.gov/qual/chesttubes.htm Free DVD
The End

Questions??

- Sue Dill Calloway RN, Esq. CPHRM
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education
- Board Member
  Emergency Medicine Patient Safety Foundation
- 614 791-1468
- sdill1@columbus.rr.com
- Resources follow

Just Culture Primer


Find Related Resources by...

Resource Type:
- Book/Report

Target Audience:
- Health Care Executives and Administrators
- Non-Health Care Professionals

Approach to Improving Safety:
- Prevention
- Learning
- Culture
- Patient Safety

Original Sponsor:
- United States of America
http://www.ahrq.gov/qual/errorsix.htm

Tools and Resources
Background

Advancing Patient Safety: A Decade of Evidence, Design, and Implementation
AHRQ’s 2009 Funded Projects to Prevent Health Care-Associated Infections
Ending Health Care-Associated Infections
To Err Is Human: Building a Safer Health System. Institute of Medicine report on health care-associated infections: tools & resources
Improving Patient Safety Through Simulation Research
Methodological Shortcomings and Estimates of Adverse Events: Technical Review
National Survey on Consumer Experiences With Patient Safety and Quality
Patient Safety: Achieving a New Standard for Care: Institute of Medicine report on health care data standards
Patient Safety and Health Information Technology E-newsletter Archives
Patient Safety Research Highlights: Program Brief


What’s New in Safety Culture
View all AHRQ PSIetet resources on Safety Culture
Editor's Picks for Safety Culture

From AHRQ webMM

In Conversation with... David Marx, JD. AHRQ WebM&M [serial online]. October 2007
Establishing a Safety Culture: Thinking Small. Timothy J. Hoff, PhD. AHRQ WebM&M [serial online]. December 2006
In Conversation with... J. Bryan Sexton, PhD, MA. AHRQ WebM&M [serial online]. December 2006

Journal Article


Journal Articles

**Resources**

- **Commentary:** Balancing "no blame" with accountability in patient safety. Wachter RM, Pronovost PJ. N Engl J Med. 2009;361:1401-1406


- **Commentary:** Creating a fair and just culture: one institution's path toward organizational change. Connor M, Duncombe D, Barclay E, et al. Jt Comm J Qual Patient Saf. 2007;33:617-624
Resources

- Do you hold staff accountable for safety? Terry K. Hosp Health Netw. February 2010

- From a blame culture to a just culture in healthcare. Khatri N, Brown GD, Hicks LL. Health Care Manage Rev. 2009;34:312-322.


Resources


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Thank you for attending!

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