Uncovering Patient Safety and the “Just Culture” Theory

Wednesday, May 21st, 2014
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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
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
Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

ADVERSE EVENTS IN HOSPITALS:
NATIONAL INCIDENCE AMONG
MEDICARE BENEFICIARIES

Daniel B. Levinson
Inspector General
November 2010
OIG-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??
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  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland  21244-1850

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 (SAs) - Comprehensive Patient Safety Reporting Using AHRQ Common Formats

Ref: S&C: 13-19-HOSPITALS

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...
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
Welcome to the PSO Privacy Protection Center

The Patient Safety Organization Privacy Protection Center (PSOPPC) was created by the Agency for Healthcare Research and Quality (AHRQ) to support the implementation of the Patient Safety and Quality Improvement Act (PL-109-41) passed by the United States Congress in July, 2005. The PPC provides technical assistance to PSOs by ensuring patient safety event data is nonidentifiable for data submission and reporting to the NPSD, and provides technical assistance on use of Common Formats. Read more about the PPC.

hwwwww.psoppc.org/web/patientsafety
Hospital Common Formats

Through a contract with the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF) solicited feedback on the formats from private sector organizations and individuals. The NQF, a nonprofit organization that focuses on healthcare quality, then convened an expert panel to review the comments received, and provide feedback to AHRQ. Based on the expert panel's feedback, AHRQ further revised and refined the Common Formats that are now available as Hospital Common Formats Version 1.2 & 1.1.

The following Hospital Common Formats are active for reporting are available for implementation and use by healthcare providers and Patient Safety Organizations (PSOs). These versions of the Common Formats are also accepted by the PSCPPC for national reporting.

Hospital Common Formats - Version 1.2
- Event Descriptions, Sample Reports & Forms
- Technical Specifications
- Users Guide

Hospital Common Formats - Version 1.1
- Event Descriptions, Sample Reports & Forms
- Technical Specifications
- Users Guide
Healthcare Reform

- 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.
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

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.
Just Culture

- 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
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
## The Just Culture Algorithm

### Event Investigation

**Rule 1**
Causal Statements should clearly show the "cause and effect" relationship.

**Rule 2**
Negative descriptions (e.g. poorly, inadequate) should not be used in causal statements.

**Rule 3**
Each human error should have a preceding cause.

**Rule 4**
Each procedural deviation should have a preceding cause.

**Rule 5**
Failure to act is only causal when there was a pre-existing duty to act.

### System Investigation

- Employee to manage personal risk?
- Organizational control of performance shaping factors?
- Organizational control of skill/competency?
- Organizational maintenance of high perceptions of risk?
- Barriers put in place to prevent error?
- Recovery to correct error before becoming a critical outcome?
- Redundancy to allow success through multiple paths?

### The Response to An Event

**Single Human Error**
- Console employee
- Conduct Human Error Investigation

**At-Risk Behavior**
- Coach employee
- Conduct At-Risk Behavior Investigation

**Reckless Behavior**
- Counsel employee
- Use remedial action to change behavior, where appropriate
- Use disciplinary action to change behavior

**Repetitive Errors or At-Risk Behaviors**
- Investigate to determine source of repetitive errors or at-risk behaviors
- If source resides in system, change the system
- If source is within employee, consider remedial and then punitive action to address risk

### Definitions

- **Purpose** – conscious objective to cause harm
- **Social utility** – the societal benefits derived from a behavior, the value the judging body puts on the behavior
- **Counseling** – a first step disciplinary action: putting the employee on notice that performance is unacceptable
- **Human error** – inadvertently doing other than what should have been done: a slip, lapse, mistake
- **At-risk behavior** – behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified
- **Substantial and unjustifiable risk** – a behavior where the risk of harm outweighs the social utility associated with the behavior

### At-Risk Behavior Investigation

- What type of at-risk behavior?
  - Error in risk vs. utility decision?
  - Failure to make risk vs. utility decision?
- Why was the decision made?
  - Incentives to cut the corner?
  - Perceptions of risk?
- How prevalent is the behavior?
  - Individual or group?
  - Rate?

### Human Error Investigation

Explain human errors by identifying the performance shaping factors:

- Information
- Equipment/tools
- Job / task
- Qualifications / skills
- Individual factors
- Environment/facilities
- Organizational environment
- Supervision
- Communication

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Copyright 2005 Outcome Engineering – Version 1.1  Mar 2005
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

<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product of our current system design and behavioral choices</strong></td>
<td><strong>A choice: risk believed insignificant or justified</strong></td>
<td><strong>Conscious disregard of substantial and unjustifiable risk</strong></td>
</tr>
<tr>
<td>Manage through changes in:</td>
<td>Manage through:</td>
<td>Manage through:</td>
</tr>
<tr>
<td>- Choices</td>
<td>- Removal of incentives for at-risk behaviors</td>
<td>- Remedial action</td>
</tr>
<tr>
<td>- Processes</td>
<td>- Creation of incentives for healthy behaviors</td>
<td>- Punitive action</td>
</tr>
<tr>
<td>- Procedures</td>
<td>- Situational awareness</td>
<td></td>
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<tr>
<td>- Training</td>
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<tr>
<td>- Design</td>
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<tr>
<td>- Environment</td>
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</tbody>
</table>

#### Console

#### Coach

#### Punish
Just Culture Video

Understanding Just Culture (Audio/Video item)

CUSP Toolkit

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 swf [ 5 minutes 32 seconds]
Just Culture Policy

POLICIES AND PROCEDURES

SUBJECT: SAFE AND JUST CULTURE

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 health care 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 walk abouts
Evaluation of the culture of safety: survey of clinicians and managers in an academic medical center


Qual Saf Health Care 2003 12: 405-410
DOI: 10.1136/qhc.12.6.405

Updated information and services can be found at:
http://qshc.bmj.com/content/12/6/405.full.html

These include:

References
This article cites 12 articles, 2 of which can be accessed free at:
http://qshc.bmj.com/content/12/6/405.full.html#ref-list-1

Article cited in:
http://qshc.bmj.com/content/12/6/405.full.html#related-urls

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.
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 to:
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 2006. 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 yearly through at least 2012.

Hospital Survey Toolkit

Survey Form

- Hospital Survey—English (PDF Version, 170 KB [PDF Help]; Word® Version, 155 KB).
- Facility version: For hospitals and/or ambulatory and outpatient facilities (PDF Version, 300 KB [PDF Help]; Word® Version, 155 KB).
- Hospital Survey—Spanish (PDF Version, 200 KB [PDF Help]; Word® Version, 120 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 and Description of Translation Process (PDF Version, 240 KB [PDF Help]; Word® Version, 68 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. The Guide includes information on getting started, 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 asks for 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 deviation, 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 most of your clinical services.

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

☐ a. Many different hospital units/No specific unit
☐ b. Medicine (non-surgical) ☐ h. Psychiatry/Mental health ☐ n. Other, please specify:
☐ c. Surgery ☐ i. Rehabilitation
☐ d. Obstetrics ☐ j. Pharmacy
☐ e. Pediatrics ☐ k. Laboratory
☐ f. Emergency department ☐ l. Radiology
☐ g. Intensive care unit (any type) ☐ m. Anesthesiology

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

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

53
### SECTION A: Your Work Area/Unit (continued)

Think about your hospital work area/unit...

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. We are actively doing things to improve patient safety</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>7. We use more agency/temporary staff than is best for patient care</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>8. Staff feel like their mistakes are held against them</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>9. Mistakes have led to positive changes here</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>10. It is just by chance that more serious mistakes don't happen around here</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>11. When one area in this unit gets really busy, others help out</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>12. When an event is reported, it feels like the person is being written up, not the problem</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>13. After we make changes to improve patient safety, we evaluate their effectiveness</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>14. We work in &quot;crisis mode&quot; trying to do too much, too quickly</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>15. Patient safety is never sacrificed to get more work done</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>16. Staff worry that mistakes they make are kept in their personnel file</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>17. We have patient safety problems in this unit</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>18. Our procedures and systems are good at preventing errors from happening</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</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 or person to whom you directly report.
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)
10 Dimensions of Safety

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

This AHRQ-supported study discusses one of the best-studied tools to measure and assess patient safety culture. Investigators present the cumulative findings from administering the Safety Attitude Questionnaire (SAQ) to more than 10,000 providers in 203 clinical areas and in 3 countries. The domains that encompass provider attitudes include teamwork climate, safety climate, perceptions of management, job satisfaction, working conditions, and stress recognition. The authors describe their findings with a goal that their tool will allow health care organizations to measure safety attitudes and compare themselves across domains to others. A past study described the results of using such a tool in an academic medical center.
The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research

John B Sexton, Robert L Helmreich, Torsten B Neilands, Kathy Rowan, Keryn Vella, James Boyd and Peter R Roberts.

The University of Texas Center of Excellence for Patient Safety Research and Practice, The University of Texas – Houston Medical School, Houston, USA

Intensive Care National Audit & Research Centre, London, UK

Royal Cornwall Hospital, Truro, Cornwall, TR1 3LJ, UK

Medical Research Institute of New Zealand, Wellington, NZ; University of Texas – Houston Medical School, Division of General Medicine, Department of Medicine (EIJ), USA

The electronic version of this article is the complete one and can be found online at: http://www.biomedcentral.com/1472-6963/6/44

Abstract

This article is Open Access and is distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.
Safety Culture

- 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
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
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 (e.g., 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.
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 health care 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.
- 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

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 website\(^1\) and transmittals\(^2\)

1 www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

2 http://www.cms.gov/Transmittals/01_overview.asp
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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<th>Description</th>
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<tr>
<td>A</td>
<td>Hospitals</td>
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<tr>
<td>AA</td>
<td>Psychiatric Hospitals</td>
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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
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.
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).
Operations  Patient Safety Program

- 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.
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
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
EP10. The hospitals 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
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/
Patient Safety and Quality
An Evidence-Based Handbook for Nurses

Nurses play a vital role in improving the safety and quality of patient care—not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need to know what proven techniques and interventions they can use to enhance patient outcomes.

To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality—Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043).

Experts in the field reviewed the literature, and their contributions are grouped into these sections:

- Patient Safety and Quality
- Evidence-based Practice
- Patient-centered Care
- Working Conditions—Work Environment
- Critical Opportunities for Patient Safety and Quality
- Tools

Select to download the Entire Volume as a PDF file (10 MB) or individual chapters (below). All PDF files are accessible. PDF Help.

Select for Ordering Information.

Edited by Ronda G. Hughes, Ph.D., M.H.S., R.N., of AHRQ

Contents

Introduction

Foreword
Carolyn M. Clancy, M.D., and Lisa Lavizzo-Mourey, M.D., M.B.A.

Preface—General Overview/Executive Summary
Ronda G. Hughes, Ph.D., M.H.S., R.N.

Peer Reviewers

Contributing Authors
Formats for Collecting Patient Safety Information

- 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
Welcome to AHRQ's Patient Safety Organization Web site

Through the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act), Congress authorized the creation of Patient Safety Organizations (PSOs) to reduce the incidence of events that adversely affect patient safety. PSOs are designed to improve the quality and safety of U.S. health care by encouraging clinicians and health care organizations to report and share—voluntarily—data on patient safety events without fear of legal discovery.

The Agency for Healthcare Research and Quality (AHRQ) administers the provisions of the Act dealing with PSO operations. This Web site is designed to give you an understanding of the:

- Purpose and goals of PSOs

Sign Up for Patient Safety Organization E-mail Updates
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
CHAPTER 2: Creating and Sustaining a Culture of Patient Safety
- Leadership Structures & Systems (Safe Practice 1)
- Culture Measurement, Feedback and Interventions (Safe Practice 2)
- Teamwork Training and Team Interventions (Safe Practice 3)
- Identification and Mitigation of Risks and Hazards (Safe Practice 4)
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.
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?
Patient Safety Leadership WalkRounds™

By using Patient Safety Leadership WalkRounds™ weekly, senior leaders of health care organizations can demonstrate to staff the organization’s commitment to building a culture of safety. WalkRounds are conducted in patient care departments (such as the Emergency Department, Radiology Department, and operating rooms), the pharmacy, and laboratories. They provide an informal method for leaders to talk with front-line staff about safety issues in the organization and show their support for reporting of errors.

This tool describes the format for WalkRounds, suggests questions to ask staff, and indicates which senior leaders should participate and where to conduct the rounds. Review and modify the instructions as needed for your organization before initiating this program. Many organizations that have conducted WalkRounds™ in conjunction with Safety Briefings have achieved greater success in changing the culture than organizations that use either tool alone. Focusing solely on safety during these rounds is a more successful strategy for promoting creating a culture of safety than digressing to other topics such as budgets and patient satisfaction.

This tool contains:
- Background
- Why Should Organizations Implement WalkRounds™?
- Aims
- Measures of Success
- Instructions for WalkRounds™
- Senior Leaders Script for WalkRounds™
Implementing Patient Safety Leadership WalkRounds™

The WalkRounds process is designed to accomplish the following goals:

- Increase awareness of safety issues among all clinicians and leaders.
- Make safety a high priority for senior leadership.
- Educate staff about patient safety concepts such as a “just culture.”
- Obtain information collected from staff about barriers to safety.
- Act, after careful analysis, on information collected from staff.
- Consistently give feedback to frontline providers and leadership on processes.

In preparation to implement WalkRounds:

1. Identify the core WalkRounds team. This group should consist of at least one senior executive, a patient safety officer/manager, a scribe (usually a member of patient safety or administrative staff), and the manager or director of each unit to be visited on the rounds.

2. Establish formal methods for reporting feedback from the rounds to senior executives, physician leaders, patient safety/quality committees, and the Board.
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 infections
  - 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 healthcare 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 blood stream infections. Be vigilant preventing central line-associated blood stream 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 at more than evidence and identify best practices, analyze care delivery, track performance with metrics, layer interventions, and continue to improve. Ordering information for Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement (AHRQ Publication No. 08-0075) is available at http://www.ahrq.gov/qual/vtguide/.

4. Educate patients about using blood thinners safely. Patients who have had surgery often leave the hospital with a new prescription for a blood thinner, such as warfarin.
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/
10 Patient Safety Tips for Hospitals

- 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
10 Patient Safety Tips for Hospitals

- 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??

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- Board Member
  Emergency Medicine Patient Safety Foundation
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- Resources follow
Just Culture Primer

Accountability is a concept that many wrestle with as they steer their organizations and patients toward understanding and accepting the idea of a blameless culture within the context of medical injury. Marx presents the concept from the legal perspective but does so for the non-barrister. Written prior to the acceptance of open disclosure or general policy support of it, the primer thoughtfully outlines the complex nature of deciding how best to hold individuals accountable for mistakes. Four key behavior concepts serve as the structure for the paper: human error, negligence, reckless conduct, and knowing violations. How they are applied to various situations in health care and how the individuals involved should be disciplined provide thoughtful reading.


Related Resources

ORGANIZATIONAL POLICY/GUIDELINES

Dana-Farber Cancer Institute Principles of a Fair and Just Culture.
Boston, MA: Dana-Farber Cancer Institute.
Medical Errors & Patient Safety

Sign Up for Medical Errors & Patient Safety E-mail Updates
Sign Up for Patient Safety and Health Information Technology E-Newsletter
Sign Up for Surveys on Patient Safety Culture E-mail Updates

You Are Here: AHRQ Home > Quality & Patient Safety > Medical Errors & Patient Safety

A-Z Quick Menu
Select Topic

AHRQ Home
Related Topics
National Quality Measures Clearinghouse™
CAHPS®
Health Care Innovations Exchange
Measuring Healthcare Quality
Medical Errors & Patient Safety
Patient Safety Network
WebM&M
Quality Indicators
Quality Information & Improvement

Highlights in Preventive Services
- Health Care-Associated Infections
- Patient Safety Organizations

Medical Errors/Patient Safety

Online Journals and Primers
Tools & Resources
Conferences & Workshops
Speeches & Statements
Congressional Hearings

The very critical issues of medical errors and patient safety have received a great deal of attention. In November 1999, the Institute of Medicine (IOM) released a report estimating that as many as 98,000 patients die as the result of medical errors in hospitals each year.

A major Federal initiative has been launched to reduce medical errors and improve patient safety in federally funded health care programs, and by example and partnership, in the private sector.

Online Journals and Primers
Tools and Resources

**Tools & Resources**

**Tips for Consumers & Patients**

- Five Steps to Safer Health Care
- 20 Tips to Help Prevent Medical Errors: Patient Fact Sheet
- 20 Tips to Help Prevent Medical Errors in Children
- AHRQ's Efforts to Prevent and Reduce Health Care-Associated Infections
- Be Prepared for Medical Appointments
- Blood Thinner Pills: Using Them Safely

**Watch:**

- Navigating the Health Care Video
- Advice Columns from Dr. Clancy
- Staying Active and Healthy with Blood Thinners (17.6 MB) (Transcript)
- It's Your Health: Use Your Medications Safely
- Taking Care of Myself: A Guide for When I Leave the Hospital
- Ways You Can Help Your Family Prevent Medical Errors!
- Your Guide to Preventing and Treating Blood Clots
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
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**


**Commentary:** (Mis)understanding safety culture and its relationship to safety management. Guldenmund FW. Risk Anal. 2010 Jul 8; [Epub ahead of print].


View all AHRQ PSNet resources on Safety Culture
Editor's Picks for Safety Culture

From AHRQ webM&M

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


et al. Health Serv Res. 2006;41:1599-1617.

Book/Report


Resources

- **Commentary:** Balancing "no blame" with accountability in patient safety  

- **Book/Report:** Patient Safety and the "Just Culture": A Primer for Health Care Executives  
  Marx D. New York, NY: Columbia University; 2001

- **Commentary:** Creating a fair and just culture: one institution's path toward organizational change  
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


This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.
Thank you for attending!

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