Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

The Patient Safety Story

Kris Brockman ATC, CPHQ, CPPS
Process Improvement Specialist, Foundation Health Partners

Presentation developed by Linda Michel, Director Rural Quality, WSHA

STATE of ALASKA Department of Health and Social Services

This presentation is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206 Rural Hospital Flexibility Program.

June 28, 2017

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

History of Patient Safety

1990's push began to build a quality culture in healthcare organizations.

1999 a groundbreaking report, *To Err is Human: Building a Safer Health System,* was published that estimated the number of hospital deaths related to preventable medical errors was possibly as great as 98,000 per year. In 2000 the Report Brief was released.

The report set all of healthcare on a **patient safety culture journey** that continues today**.**

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

What Happened?

As a result of the 1999 report there were Congressional hearing with:

- Governmental agencies
- Professional groups
- Accreditation organizations
- Insurers, and others

These entities responded quickly with plans to develop reporting systems that would hold accountability for organizations.

Reporting alone does not make systems safer!

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Did it Change the Culture?

Advances have been made in reporting errors, but adverse events has not changed much. AHRQ reports continue to indicated that deaths related to error remain similar to the statistics cited in 1999.

- In 2009 **thousands** of patients developed central-line-associates blood stream infections, **and one in seven hospitalized Medicare patients** experience one or more adverse events.
- In 2009 **preventable adverse events** among adults (excluding OB) per year in U.S. hospitals was **3,023,000**, according to the AHRQ, 2013 report.
- 2013 NHQR states the harm associated with hospital stays from 2000-2007 was **25.1 per 100 admissions**.

Do No Harm!

Basic principles of patient safety

1. Patient Safety emerges from system design; systems that make risky or high volume interventions reliable.

   Safety systems have many components that can contribute to errors:

   - Procedures
   - Environment
   - Design of material used
   - Training that has been done
   - Culture of the team caring for the patients(s)

Do No Harm!

2. Patient Safety is designed for the nature of illness.

   When a patient comes to your healthcare facility they are already ill. Something in their body has gone wrong. Failure to provide the correct care causes further harm to the patient.

   Standardization decreases the opportunity for errors.

Do No Harm!

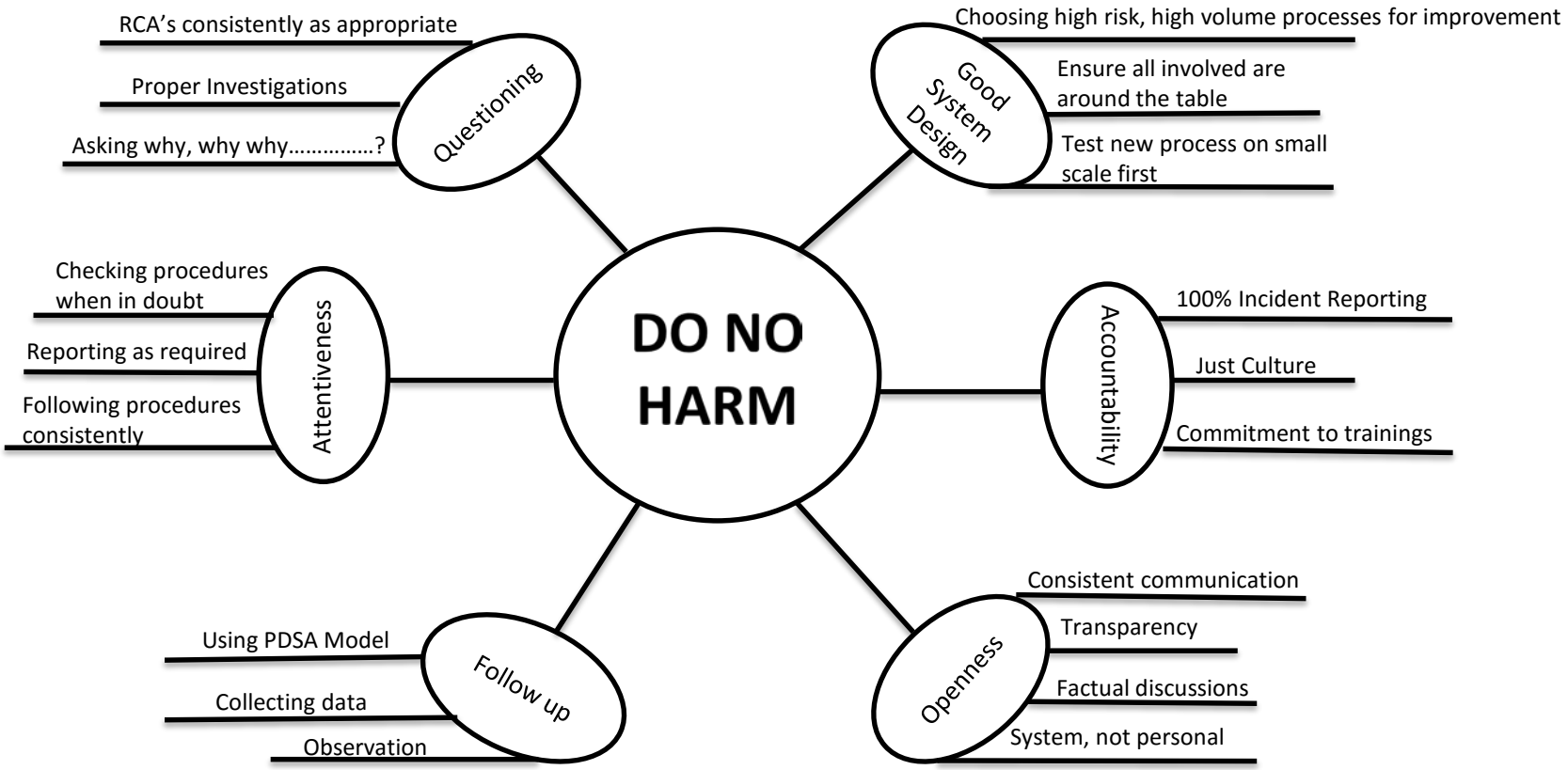
3. Patient safety is dependent on open learning.
   - Organizational and personal accountability is a must. However, everyone must also recognizing that most errors are caused by flaws in the process rather than the person.

4. Trustworthiness is essential to the concept of patient safety.
   - The members of the healthcare team must trust each other to speak up when an error or a potential error is identified.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association



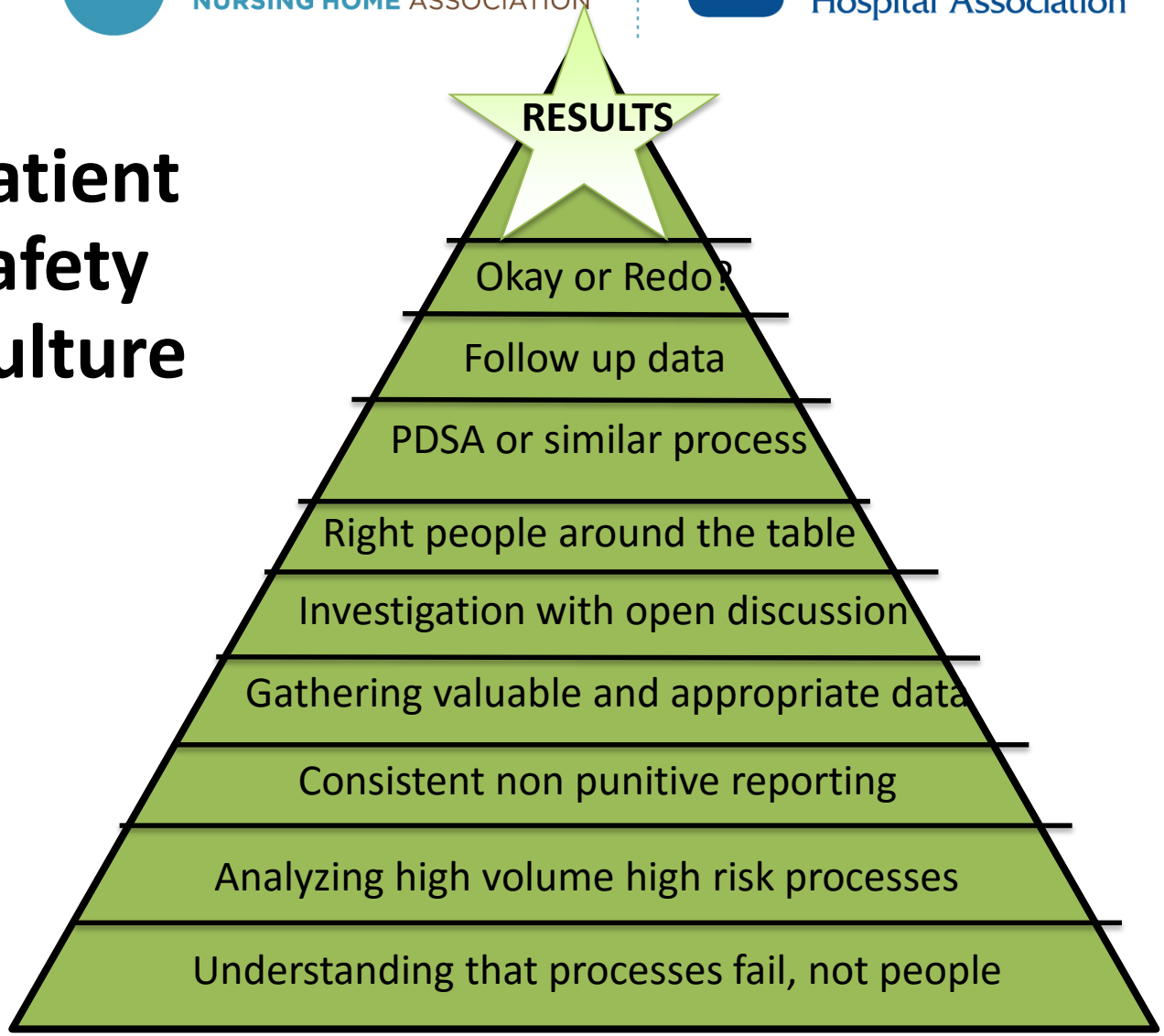
Patient Safety Culture

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Patient Safety Culture



Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

IOM Report in 2000

The report said the current healthcare system contained:

- Fragmented care.
- Concerns about medical liability.
- Lack of preventative services.
- Lack of incentives from 3rd party purchasers to provide financial incentive to healthcare organizations to improve patient safety and quality.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

IOM Report in 2000

"The IOM report recognized that the **majority** of medical errors are not the result of 'individual recklessness' or action of an individual or group intent on doing harm. More often, the errors are results of faulty systems, processes, and conditions that lead individuals to make mistakes, or at least fail to prevent mistakes.

It also suggested that when an error occurs, the individual who made the error should not be reprimanded, as this has not shown to be effective in making the system better nor preventing someone else from making the same error.

Directly from "*Healthcare Quality Handbook;*" Janet A. Brown, RN, CPHQ, FNAHQ

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Categories of Errors in the Report

1. Communication
   - Error or delay in diagnosis.
   - Failure to order.
   - Use of outmoded test or therapies.
   - Failure to act on the results of monitoring or testing.

2. Treatment
   - Error in the performance of a procedure or test.
   - Error in the administration of the treatment.
   - Error in the dose or method of using a drug.
   - Avoidable delay in treatment or responding to a test results.
   - Inappropriate care.

Categories of Errors in the Report

3. Preventative
   - Failure to provide prophylactic treatment.
   - Inadequate monitoring.
   - Follow-up treatment.

4. Other
   - Failure of communication.
   - Equipment failure.
   - Other system failures.

"Healthcare organizations must be aware of these categories of error as they examine the patient safety risks in their organizations."

Directly from "*Healthcare Quality Handbook;*" Janet A. Brown, RN, CPHQ, FNAHQ

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

The Callings of the Report

Strategy to improve patient care:

- Establish a national focus to create leadership tools, research, and protocols to increase the knowledge base about patient safety.
- Identify and learn from errors by developing a nation-wide public mandatory reporting system as well as encouraging healthcare staff, practitioners, and the organization to participate in voluntary reporting programs.
- Raising performance expectations and standards for improvement in patient safety through the professional organizations, group purchasers, and so forth within healthcare.
- Implementing patient safety systems in healthcare organizations and systems to ensure safe practices at the delivery area.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

The Callings of the Report

For Congress to create a Center for Patient Safety that would set national patient safety goals and track the progress of those goals.

- Implement research.
- Identify prototype safety systems.
- Provide tools for identifying and analyzing errors.
- Recommend additional improvements.

The report suggested that the center should be housed in the Agency for Healthcare Research, because they had a large infrastructure to support quality and safety.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

The Callings of the Report

With the mandatory reporting systems:

- The states would be required to develop a process to collect information regarding adverse events that resulted in death and serious harm.
- The reporting systems should begin with hospitals
- Produce a system that would hold organizations accountable for these errors and lead to transparency to the public and others.

At the time of the report, about one third of the states already had such a system in place.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

The Callings of the Report

Voluntary reporting systems would complement the mandatory reporting and:

- Should focus on a much broader set of errors and issues, especially those that did not result in major harm or death.
- Utilized to examine the process that are producing the errors before there is harm or death.
- Congress would have to enact laws to protect the confidentiality of the information collected.

A definition of minimum performance levels should be established through regulatory and other means such as:

- Licensing
- Certification
- Accreditation

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

The Calling of the Report

The healthcare organization must develop a culture or patient safety through:

- The workforce and processes focusing on improving reliability and safety of care for patients.
- Patient safety being an organization goal.
- An initiative that all healthcare organization strive to improve.
- Systems for continuously monitoring patient safety must be developed and utilized to make improvements.
- The data must be utilized to identify areas for improvement and then to measure if improvement have occurred and are sustained.

History in the Making

Within 1 year of the report first being published AHRQ had already implemented:

- Developing and testing of new technologies to reduce medical errors.
- Conducting large-scale demonstration projects.
- Supporting multidisciplinary teams to develop new knowledge to be utilized in the demonstration projects.
- Supporting projects for better understanding of how the environment affect the ability of providers to improve safety.
- Funding researchers and organizations to develop, demonstrate, and evaluate approaches to education of providers and others in order to reduce errors.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

History in the Making

In 2013, the AHRQ released a report and published these 10 Patient Safety Practices, as a result of studying their initial activities outcomes, that were **strongly encouraged** for adoption:

1. **Hand hygiene.**
2. Barrier precautions to prevent **healthcare-associated infections.**
3. *"Do Not Use"* list of hazardous abbreviations.
4. Preoperative checklists and anesthesia checklists.
5. Use of real-time ultrasound for central line placement.
6. Bundles that include checklists for **central line** insertion and care.
7. Bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine and subglottic-suction endotracheal tubes.
8. Interventions to reduce **urinary catheter** use, including catheter reminders, stop orders, or nurse-initiated removal products.
9. Multicomponent interventions to reduce **pressure ulcers.**
10. Interventions to improve prophylaxis for **VTE.**

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

History in the Making

There were also 12 PSPs that had sufficient evidence of effectiveness that they should also be **encouraged** for adoption.

1. Multicomponent interventions to **reduce falls.**
2. Use of clinical pharmacist to reduce **adverse drug events.**
3. **Computerized** provider order entry.
4. **Medication Reconciliation**.
5. Obtaining informed consent to improve patients' understanding of the potential risks of procedures.
6. Use of surgical outcome measurements and reports cards.
7. Practices to reduce **radiation exposure** from fluoroscopy and CT exams.
8. Documents of patients preference for life-sustaining treatment.
9. Rapid response systems.
10. Utilization of complementary methods for detecting **adverse events**/medical errors to monitor for patient safety problems.
11. Team Training.
12. Use of simulation exercise in patient safety efforts.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Federal Government Joins the Efforts

In 2005 the government passed The Patient Safety and Quality Improvement Act of 2005 (PSAQI) establishing confidentiality and privilege protections for patient safety.

The act includes language that states that no matter how it is defined, and organization must have a culture of safety.

This means that certain actions surrounding patient safety improvement activities are protected and confidential:

- Allowing those who work on a patient safety improvement project to work as transparently as possible.
- Encourages the reporting and discussion of an adverse event, near miss, or other dangerous condition.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Patient Safety Organizations

In 2003,The Joint Commission established National Patient Safety Goals for all healthcare organizations that they accredited. Other entities also established the same sort of goals including:

- **WHO** Collaborating Centre for Patient Safety Solutions was established in 2005.
- **National Quality Forum (NQF)** was incorporated in May 1999. There charge was to identify a list of preventable, serious adverse events.
- **Institute for Healthcare Improvement (IHI)** has been working to improve patient safety for many years, and provide a website for their patient safety resources. Their goal is to work with others *"to build safety into every system of care, ensuring that patients receive the safest, most reliable care across the continuum."*

Patient Safety Organizations

- **AHRQ** Patient Safety Indicators are risk-adjusted measures that screen for potential in-hospital complications and adverse events following surgeries, procedures, and childbirth, that are divided into two primary domains, hospital-level indicators and are-level (county, state) indicators.
- **National Patient Safety Goals, or The Joint Commission's Nation Patient Safety Goals (NPSG)** are based on past sentinel event information, and include specific recommendations and/or approved alternative approaches. Each year the goals are evaluated, and national reported issues are identified for possible new goals.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Patient Safety Management Program

In 2006 the IHI developed a white paper, *Leaders in Patient Safety,* to help in the development of patient safety programs. This responsibility can not be delegated to others and recommends 8 steps for leaders to follow to achieve patient safety and high reliability in healthcare organizations.

Leadership

1. Establish patient safety as a strategic priority.
   - This strategic priority should be found in all of the plans of the organization, especially the Patient Safety Plan and the Quality Improvement Plan.
   - Must assess and establish a supportive patient safety culture.
   - Address the organization's infrastructure.
   - Learn about patient safety and improvement methods.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Patient Safety Management Program

2. Engage key stakeholders (governing board, leaders, physicians, staff, patients and family) by:
   - Educating them about patient safety.
   - Engaging them in discussions about patient safety.
   - Giving patient safety the same amount of time as financial issues on the agenda.

3. Communicate and build awareness
   - Should round routinely and engage others in discussions about patient safety.
   - Educate and do other activities within departments that address patient safety directed towards the functions of the departments.

Patient Safety Management Program

4. Establish, oversee, and communicate system-level aim by:
   - Developing a strategic plan with identified system-level goals.
   - Communicate these goals throughout the organization.
   - Include patient safety strategic objectives.

5. Measure harm over time.
   - Utilize a dashboard or balanced scorecard to see data over time for important factors identified for the organization.

6. Support staff and patients/families impacted by medical errors or harm.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Patient Safety Management Program

7. Align system strategy, measures, and improvement projects.
   - Align the strategic initiatives between various parts of the organization. For example align the quality improvement with financial plans.
   - Integrate the national initiative in the process when outlining your strategies.

8. Redesign care processes to increase reliability (key concept imbedded in patient safety).

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Patient Safety Management Program

The IHI also released the *"Governance Leadership of Safety and Improvement"* as a leadership resource for patient safety programs.

This IHI resource explains that the core of the boards fiduciary responsibility is ensuring safe and harm-free care to patients, and cannot be completely delegated the medical staff and executive leadership.

In an effort to outline the responsibilities further, they listed both generic components and general components of the program.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Generic Components

The patient safety program **includes at least**:

1. Infrastructure: senior leaders roles, patient safety officer, government teams, software.
2. Clear linkage with quality strategy; Integration of all related functions and safety program; Alignment with strategic goals.
3. Policies, procedures, and education to reduce and control risk to patients and staff.
4. An occurrence/event/incident reporting process.
5. Mechanisms to participate in nation patient safety initiatives.
6. Proactive activities to identify high-risk processes and implement actions to reduce avoidable risk.
7. A process for immediate response to medical errors and sentinel events.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION | Washington State Hospital Association

General Components

8. Performance measurement, tracking and analysis.
9. Improvement activities.
10. Documentation and reporting.

All healthcare organizations across the continuum are expected to implement specific patient safety programs, as defined by CMS and accreditation standards. There are 12 **generic components** inherent to a patient safety program that are taken from select accreditation standards.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

General Components

1. Organizational wide program implemented by leadership.
2. Leadership to manage program include (but not limited to) directors, managers, safety officers, and clinical leadership that includes providers, nurses, ancillary personnel and frontline clinical staff.
3. Scope includes potential or no harm errors to hazardous conditions and sentinel events.
4. All departments, program and services should participate in the patient safety program.
5. As a part of the program, leaders create procedures for responding to system or process failures.
6. Leaders provide and encourage a blame-free internal reporting system.

Patient Safety Program

7. Communicate the definition of “sentinel event” throughout the organization.
8. Conducts thorough and credible root cause analysis in response to sentinel events.
9. Make support systems available for staff that have been involved with an adverse or sentinel event understanding that they are the “second victim” of the event and require support.
10. Select one high risk process and conducting a proactive risk assessment should occur at least every 18 months.
11. Analyze and then use information about system or process failure to improve safety and reduce risks.
12. Lessons learned from root cause analysis, system or process failures, and the results of proactive risk assessments should be shared with all staff providing services for the specific situation, and up the chain of command to the governing board.

Partnership for Patients

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

QUESTIONS?