Patient Safety –
It Takes a Village.....
but it starts with You!

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Patient Safety Journey

Hippocrates
- 4th Century BC
- First Do No Harm
“It may seem a strange principle to enunciate, as the very first requirement in a hospital that it should do the sick no harm”

Florence Nightingale, Notes on Nursing, 1869

IOM...1999
It must be better by now... right?

5 years

- Improvements
- Reporting
- Leadership
- Gaps
- IT
- Accountability

10 years

- Improvements
- Reporting
- Malpractice
- Gaps
- Regulatory / accreditation
- HIT
- Workforce training

(Wachter, 2004; Wachter 2010)
The people – the devastation......

Betsy Lehman
Dana Farber 1995

1999

IOM

2003

2007

2009

2011

Jessica Santillan
Quaid T

Nora Bostrom

Patient Safety Impact on Mortality.... Going in the Wrong Direction

2008

• 11th leading cause of death

2013

• 3rd leading cause of death

Medicare

• 4 by 8% / year for MI
• 4 by 8% / year for CHF
• No change in pneumonia
• No change in post-op complications

All patients

• 2010: 145 AE / 1000 hospitalizations
• 2014: 121 AE / 1000 hospitalizations
• 16.3% improvement
• 2.1 million fewer harms
• $555$ BILLIONS saved

Adverse Events: 2005 - 2011

Kronick
Adverse Events

- Decrease 4.5% year –
  - Sounds great, right?
- By 2025
  - We would have half as many AE as we had in 2010
  - WAY too slow…..

Are you willing for your family member to be the one who…

Objectives

- Describe the patient safety journey
  - Where have we been… we are going… and why is it taking so
    long to get there?
- Relate the concepts of a patient safety culture with high
  reliability organizations
  - Do you work in a highly reliable organization?
- Discuss the role of the NURSE in creating and sustaining a
  safety culture and moving toward high reliability
  - Just Culture
  - QSEN competencies

Patient Safety Journey

- IOM
  - Safe
  - Timely
  - Effective
  - Efficient
  - Equitable
  - Patient-Centered
- Safety Culture
- Just Culture
- High Reliability
**Patient Safety Culture**

*A way of thinking, behaving, or working in a place / organization*

- Foster a Learning Environment
- Evidence based practice
- Healthy Work Environment
- Decreased risk for adverse outcomes

**Goal of Patient Safety**

- Minimize the risk of *harm* to patients and providers through system effectiveness & individual performance
AONE Guiding Principles in Patient Safety

Lead Cultural Change

- Develop Leadership Competencies
- Patient Safety
- Provide Shared Leadership
- Build External Partnerships

Patient Safety Culture: What does it look like?

- Trust
  - Peers and leaders
- Report
  - Errors
  - Near misses
  - Risk
  - Recognize & reward
- Improve
  - Unsafe conditions
- Accountability
  - Human error
  - Willingness to disclose error
Role of Nursing Leadership in Creating a Culture of Patient Safety

- Knowledge, tools & resources
- Executive Leadership
- Workforce knowledge & skills
- Engage pts / families
- Culture of Safety
- Transparency in reporting & feedback
- Safety should be a design element
- Audit / monitoring plan
- Safety awards

Empowered

- Be heard
- Feel Important
- Stop the Line.....

Patient Safety Culture

Examples of Stop the Line
- Hand hygiene violation
- Wrong site surgery
- Medication administration

Teamwork is a requirement to work in this organization
Subcultures in a Patient Safety Culture

- Reporting Culture
- Just Culture
- Flexible Culture
- Learning Culture

Just Culture

“an environment where professionals believe they will receive fair treatment if they are involved in an adverse event and trust the organization to treat each event as an opportunity for improving safety”

Just Culture Behaviors

- **Human error** - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.
  - Misreading of blood sugar value, administer wrong coverage
- **At-risk behavior** – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
  - Skip independent double check
  - Do not participate in the time-out
- **Reckless behavior** – behavioral choice to consciously disregard a substantial and unjustifiable risk
  - Refusing to do OR count
  - Coming to work under the influence
Just Culture Accountability

| Human errors: slips, lapse, or mistakes | Managed through: Processes, procedures, training and design: Console |
| At-Risk Behavior: a choice — risk not recognized or believed justified | Removing incentives for at risk behavior and creating incentives for health behavior and increasing situational awareness: Coach |
| Reckless behavior — a conscious disregard of unreasonable risk | Remedial action or punitive action: Punish |

Just Culture: Examine these 2 cases

Sam is a very experienced CC nurse. His patient was on norepinephrine and the bag needed to be changed. Everyone was busy, so he did not get an IDC. At change of shift, it was noted that the infusion was the wrong concentration and he was giving the patient half the dose he thought. No harm, no foul.

Marie’s patient was receiving a dilaudid infusion on the PCA pump. Marie did not get an IDC, she didn’t think she needed it. Because her patient’s dose was half (wrong concentration), he went into a pain crisis and needed extra IV doses of Dilaudid and Ativan to get under control.

Are these cases different?
- Behavior = Same
- Outcomes = Totally different
- Management = Should be the same

Application of Just Culture

- Leadership rounding
- Employee recognition
- Transparent communication about reported patient safety events
- Mentoring and coaching
- Fair and just accountability principles
- Gathering feedback from employees

Patirician et al. 2016
**Build External Partnerships**

- Academics
- Technology
- Communities
- Policy Makers
- Regulatory Agencies
- Professional Organizations
- Patient

**Culture of Safety: How do we measure?**

- Required by Joint Commission
  - AHRQ survey
  - VHA
  - Westat

**AHRQ Culture of Safety Survey**

- Culture of Safety Survey
  - Non-punitive response to error
  - Handoffs and transitions
  - Staffing
Non-punitive Response to Error

- Fair and reasonable response to error
- Punishment for slips, lapses, mistakes: have no impact
- DO NOT focus on the outcome, but focus on the behavior

Behaviors
- Human error — action that cannot be reduced by punishment
- Negligence — should have been aware of the risk, but failed to exercise expected care
- Intentional rule violation — conscious violation of safety rule
- Reckless conduct — conscious disregard of substantial and unjustified risk

Handoffs and Transitions: A Time of Vulnerability

- Transition: patient moves from one care setting to the next
- Handoffs: the communication between health care workers during these transitions
- Up to 80% of serious medical errors may be related to miscommunication during handoff
  - Information is omitted 30-40% of the time
  - Incorrect information is shared 13% of the time

Handoffs and Transitions: Vulnerability

- Handoffs
  - Shift reports that are pre-populated with pertinent data from the EMR
  - Structured formats for report, such as SBAR or PACE

- Teamwork: Key to handoffs and transitions
  - Poor communication (intimidating and disruptive behavior) can undermine safety
  - Refusing to answer pages, staff not calling to clarify an order because of fear they will be “yelled at”
  - Zero tolerance for disruptive behavior
Safe Staffing

- Increased adverse events with:
  - Insufficient staffing
  - Excessive workloads
  - Worker fatigue
  - Immune system, metabolism, cardiovascular system, and impair judgment
  - High turnover
- Joy and meaning of work necessary to transforming a safe culture

Patient Safety Journey

History
- IOM
  - Safe
  - Timely
  - Effective
  - Efficient
  - Equitable
  - Patient Centered

Safety Culture
- Just Culture

High Reliability

Goal: High Reliability
- What is high reliability?
- Organizations that achieve and sustain high levels of safety despite high potential for serious events to occur

- Wrong site surgery: 50 times/week
- Off Paws: 600 times/year
- HAI: 300 deaths/day 75,000/year
- Airlines: 1 major injury / 3.1 million flights
HRO Principles

- **Preoccupation with failure**
  - Heightened awareness of risk
  - Proactive and preemptive analysis and discussion of risk
  - Looks for abnormalities, recognize defects

- **Reluctance to simplify interpretations**
  - Question assumptions
  - Investigate all levels of risk with the same intensity

Blouin & McDonagh, Hughes; Latney

- **Sensitivity to operations**
  - Situational awareness
  - Understand the frontline work to prevent errors
  - Awareness of broad risks

- **Commitment to resilience**
  - Cope with, contain, and bounce back from adverse events

- **Deference to expertise**
  - When attempting to solve a problem, the decision making migrates to the person who has the most expertise, regardless of the level of authority or rank.
  - Organizations can respond more quickly to unanticipated events

Blouin & McDonagh, Hughes; Latney

HRO in Healthcare

- Leadership must commit to a goal of zero preventable harm
- HRO principles must be integrated with the organization to develop a culture of safety
- The organization must adopt a rigorous process improvement program to improve the quality of care and outcomes

Chassin & Loeb; Latney
**HRO Outcomes**

- **High Reliability in Health Care:**
  - Improves organizational effectiveness
  - Improves organizational efficiency
  - Improves customer satisfaction
  - Improves compliance
  - Improves organizational culture
  - Improves documentation

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**Competencies to Improve Quality and Patient Safety**

- **Patient Centered Care**
  - Decisions based on patients' values, beliefs, and preferences
  - Patient/family are treated with respect
  - Partners in care

- **Teamwork and collaboration**
  - How well teams work together
  - Nurses need skills in problem-solving, conflict resolution, and negotiation
  - Emotional intelligence

- **Evidence based practice**
  - Best evidence available
  - Spirit of inquiry

- **Safety**
  - Minimize the risk of harm to patients and providers
  - Assess system effectiveness vs individual performance

- **Informatics**
  - Thread through all competencies
  - Documentation in the EHR, with decision support and safety alerts
  - Retrieve the best evidence, manage QI data

*By Barnstainer*
Obstacles to a Safety Culture

- Healthcare is complex and inherently risk prone system
  - Tolerance of individualistic practices
  - View errors as failures and assign blame
  - Focus of training is on rules versus knowledge
  - Punish individuals... don't address the system
  - If no injury, no action
    - Outcomes should not influence response
  - Fear of retribution for reporting
  - Organizational lack of ownership for patient safety

Strategies... Start Now

- Simplify and standardize workplace, equipment, supplies and processes
- Establish constraints that encourage and drive medical professionals to do the right thing
- Reduce reliance on memory
- Foster robust communication between stakeholders
- Conduct training
- Plan interdisciplinary team training programs
- Managers and leaders continually contribute to the process of improving quality
- Culture of fairness and Accountability
- Monitor and evaluate errors
- Implement methods to reduce errors
So much to do… Where to focus?

- Eliminate unnecessary, unreliable metrics
- Develop standardized / validated metrics
- Use clinical, not administrative data

Where to Focus?

- Adverse drug events
- Hospital acquired infections
  - Only one with validated clinical data
- Venous Thromboembolism
- Pressure Ulcers
- Falls
- Surgical Complications

Top Patient Safety Strategies…

- Pre-Op / anesthesia checklists
- Bundles to include checklists to prevent central line infection
- Decrease the use of indwelling urinary catheters
- Preventing pneumonia and other infections in people on ventilators by elevating the head of the bed, sedation vacation, subglottic suctioning, oral care with chlorhexidine
- Washing hands

Shekelle, Pronovost, et al.
Top Patient Safety Strategies...

- Avoiding the use of abbreviations for medications or procedures
- Simple strategies for preventing pressure ulcers
- Gloves, gowns, and other barrier precautions to prevent healthcare-associated infections
- Using ultrasound to guide the placement of central lines
- Treatment and prevention efforts blood clots in a leg, arm, or lung (venous thromboembolism)

Shekelle, Pronovost, et al.

Safety Strategies

Healthy Work Environment

- Skilled communication
- True collaboration
- Effective decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

What does this mean to your practice?

Questions?

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Patient Safety: Takes a Village


