

Patient Safety What Does It Really Mean?

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Patient Safety
is
The Next Step
in
Process Improvement

Wake Up Calls

- IOM reports -
 - 2000 – “To err is human: Building a safer health system”
 - 2001 – “Crossing the quality chasm: A new health system for the 21st century”

Wake Up Calls

- Leapfrog – Corporate initiative
- JCAHO – Public policy action plan
- Congress – Legislative initiative

Six Key Aims of Health Care

- Safe – avoid injuries to patients
- Effective – based on science
- Patient centered – respectful, responsive
- Timely – reduces wasteful delays
- Efficient – avoid waits
- Equitable – across gender, race, location, and ability to pay

Medical Errors

- Key aspect of patient safety
- Definitions are evolving
- The “sharp end” = human factors
- The “blunt end” = system factors
- Organizational culture

Hospital Medicine
is
Too Complicated
for
Humans

Health Care at the Crossroads

Joint Commission Public Policy Initiative:
“Strategies for Improving the Medical
Liability System and Preventing Patient
Injury”

This is a public policy action plan that
involves the gathering of information and
multiple perspectives on the issue.

Physician Initiatives

- All doctors, even the nation’s best doctors, make mistakes
- “You learn from your mistakes”
- Many physicians are reluctant to embrace patient safety activities or be open about errors without assurance of protection from legal consequences
- Improve communication with patients

Regulatory Initiatives

- ABMS and AOA requiring maintenance of board certification
- Continuously meet core competency requirements respecting patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice

More Regulatory Initiatives

- FSMB pursuing Maintenance of Licensure
- In 2004, FSMB instituted a clinical and communication skills assessment as a requirement for physician licensure
- Practicing physicians responded that this should be the responsibility of medical schools prior to physician graduation

Hospital Initiatives

- More stringent review of new physician privileges as well as requiring objective measures of performance before renewing physician privileges
- Requiring peer monitoring for physicians with suspect competency
- Enforcing professionalism with zero tolerance

More Hospital Initiatives

- Study published in Health Affairs in 2005 by Devers et al concludes that the major driver for hospital patient safety initiatives Joint Commission requirements
- This requires developing better processes for reporting, analyzing, and preventing sentinel events and continually meeting patient safety standards

JCAHO Standards

- More than half of the Joint Commission's accreditation standards for hospitals are directly related to patient safety
- In addition to standards, JCAHO annually issues, and requires compliance with, its National Patient Safety Goals
- These include fundamental performance issues that can result in error including verbal orders and use of abbreviations

Healthcare Team Approach

- Must start from the top down with administrative leadership
- Team training is "team building"
- Physicians, nurses, pharmacists, technicians and ancillary personnel must be on the same page
- Patient identification is always key

Emergency Department Safety Factors

- Overcrowding
- Geography
- Workload
- Human Factors
- Staffing
- Expectations

Overcrowding

- 2007 Quality of Care survey conducted by the American College of Physician Executives reveals many frustrations for doctors trying to deliver safe, high-quality patient care
- ED physicians indicated the most pervasive problem affecting good care is overcrowding disrupting patient flow and causing huge backups in the ED

Geography

- Floor plan
- Functions
- Lines of sight
- Supplies and equipment
- Relational elements
 - Time/motion factors, fatigue
 - Availability/location of resources

Workload

- Volume
- Complexity
- Time sensitive
- Continuum of care
- Beyond the purely clinical

Human Factors

- Knowledge base
- Decision making under constraints
- Just-in-time info (clinical decision support)
- Circadian biology
- Distractions

Staffing

- Personnel shortages
- Skill set
- Orientation
- Teamwork
- Consistency

Climate of Expectation

- Patients
- Families
- Administrators
- Community
- Risk management

Approaches to Optimal

- Measure performance – individual and process
- Use resources – ACEP, JCAHO
- Team training – In-service programs
- Guidelines, protocols, pathways, order sets
- Promote safety culture

“Best Practices” Evidence-based

- ACC/AHA guidelines
- ACEP clinical practice guidelines
- AHRQ resources: “guidelines.gov”
- Institute for Clinical Systems Improvement
- National Institute of Health

Just-In-Time Information

- PDAs
- On-line services
- Standard order sets
- Feedback loops

Internal PI Process

- Statistical monitors
- Focused studies
- Case reviews
- Track by provider
- Regular Feedback
- Post on “dashboard”

Some Specifics

- Physician-directed care
- Consistent roles of support staff
- Specimen draws and labeling
- Minimizing patient movement in ED
- Verification of patient identification
- “Time out” for procedures
- Medical history and allergies

Some More Specifics

- Adequate and complete documentation
- Medication reconciliation
- Continuity of care
 - Use of consultants – physician to physician communication
 - Nursing report – fax report

Regulations/Policies

- Accuracy of patient identification
- Communication among caregivers
- Procedural verification document
- Hand hygiene
- Preventing blood transfusion errors
- Sentinel event alerts

More Regulations/Policies

- High alert medications
- Labeling operative medications
- Preventing needlestick/sharps injuries
- Medication abbreviations
- Delays in treatment

New Challenge

Notification of patients about
serious errors

- How to do it
- When to do it
- What to communicate
- Damage control

Basic Rules

- **Simpler is better**
- Make it easier to do the right thing rather than the wrong

Summary

- Focus is on patient safety
- Protocols and guidelines
- Teamwork
- Continuity of care
- Continuous quality improvement
- Consistency is key