Innovative Techniques for Residents to Improve Safety

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Modified from Tammy Lundstrom, MD
www.mihealthandsafety.org/presentations/lundstrom.ppt
What is a Safety Culture

And how is it achieved?
Lessons from a Leader

“Safety is not a priority, it’s a way of life”

In health care, physicians can “lay the foundation for aggressive quality improvement.” The key to improving quality and safety, he said, is “giving people the power and authority to make systemic changes in their environment.”

Paul O’Neill
CEO Alcoa Steel
Treasury Secretary
Culture change is the key

- Physicians need to change the way they view medical errors in order to improve patient safety. Unlike the airline industry, which seeks to understand the cause of accidents without placing blame, “medicine views errors as failings that deserve blame and fault.

- Placing blame, however, creates an atmosphere in which people are afraid to come forward to report mistakes.

James Bagian, MD, a former astronaut, director of the Department of Veterans Affairs’ National Center for Patient Safety
Culture change is the key

- The key to improving patient safety is for medical professionals to focus on the prevention of medical errors, not punishment for medical errors that have already occurred.

- Such a paradigm shift requires a cultural change in health care institutions, starting with the upper and middle management.

- The ultimate goal is not to reduce errors to zero, but rather, to protect patients from harm.

James Bagian, MD, a former astronaut, director of the Department of Veterans Affairs’ National Center for Patient Safety
### Safety Culture Involves Paradigm Shift

<table>
<thead>
<tr>
<th>OLD</th>
<th>NEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who did it?</td>
<td>What happened?</td>
</tr>
<tr>
<td>Focus on Bad Event</td>
<td>Focus on Near Miss</td>
</tr>
<tr>
<td>Root Cause</td>
<td>FMEA</td>
</tr>
<tr>
<td>(identify what how why the bad event happened)</td>
<td>(failure mode and effects analysis of systems)</td>
</tr>
<tr>
<td>Top down</td>
<td>Bottom up</td>
</tr>
<tr>
<td>Punish bad behavior</td>
<td>Fix broken processes</td>
</tr>
</tbody>
</table>
Culture change with Code Blue

♦ Get away from “Monitoring Codes”
♦ Move toward: Review previous 48 hour record
  – Could this event have been prevented?
  – Were signs of deterioration missed?
    • Elevated BP, dropping BP
    • Elevated HR, dropping HR
    • Elevated RR
Advantage of culture shift

- No patient harm, therefore no blame
- No guilt
- Focus on prevention
- No fear of litigation
JCAHO
Universal Protocol

The principal components of the Universal Protocol include:

♦ 1) Pre-operative verification process;
♦ 2) Marking of the operative site;
♦ 3) Taking a 'time out' immediately before starting the procedure; and
♦ 4) Adaptation of the requirements to non-operating room settings, including bedside procedures.
JCAHO National Patient Safety Goals

♦ Eliminate wrong-site, wrong-patient, wrong-procedure surgery
  – Use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
  – Mark the surgical site and involve the patient in the marking process.
Goal: Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.

- Develop and implement a protocol for administration and documentation of the flu vaccine and of pneumococcus vaccine.

Goal: Reduce the risk of patient harm resulting from falls.

- Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, take action to address any identified risks
- Implement a fall reduction program, including a transfer protocol, and evaluate the effectiveness of the program.
JCAHO National Patient Safety Goals

♦ All health care personnel should not wear artificial nails and should keep natural nails less than one quarter of an inch long if they care for patients at high risk of acquiring infections (e.g. patients in intensive care units or in transplant units).

♦ Reduce the risk of health care-associated infections
  – Clean hands before and after patient care
  – After using the bathroom
JCAHO
National Patient Safety Goals

♦ Accurately and completely reconcile medications across the continuum of care
  – Obtain and document a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient.
JCAHO
National Patient Safety Goals

Identify your patients with two patient specific identifiers prior to ANY procedure or giving ANY medication

♦ Inpatients:
  – Name
  – Medical Record Number

♦ Outpatients:
  – Name
  – Date of Birth
JCAHO
National Patient Safety Goals

♦ Improve the effectiveness of communication among caregivers
  – For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result
  – see next page regarding abbreviations
<table>
<thead>
<tr>
<th>Dangerous Abbreviation</th>
<th>Intended Meaning</th>
<th>Misinterpretation</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>Units</td>
<td>Mistaken as a zero or a four when poorly written, resulting in overdose. (4U seen as &quot;40&quot; or 4U seen as &quot;44&quot;)</td>
<td>Use units</td>
</tr>
<tr>
<td>µg</td>
<td>Micrograms</td>
<td>Mistaken for &quot;mg&quot; when handwritten, resulting in overdose</td>
<td>Use mcg</td>
</tr>
<tr>
<td>q.o.d. or Q.O.D.</td>
<td>Every other day</td>
<td>Misinterpreted as qd or qid if the &quot;o&quot; is poorly written.</td>
<td>Use every other day or q 48 hours and time/day to begin therapy</td>
</tr>
<tr>
<td>TIW</td>
<td>Three times a week</td>
<td>Misinterpreted as &quot;three times a day&quot; or &quot;twice a week&quot;</td>
<td>Use three times a week</td>
</tr>
<tr>
<td>cc</td>
<td>Cubic centimeters</td>
<td>Misread as &quot;u&quot; (units)</td>
<td>Use mL</td>
</tr>
<tr>
<td>AU, AS, AD</td>
<td>Both ears</td>
<td>Misinterpreted as &quot;OU&quot;, &quot;OS&quot;, and &quot;OD&quot;</td>
<td>Use both ears, left ear or right ear</td>
</tr>
<tr>
<td>OU, OS, OD</td>
<td>Both eyes</td>
<td>Misinterpreted as &quot;AU&quot;, &quot;AS&quot;, and &quot;AD&quot;</td>
<td>Use both eyes, left eye or right eye</td>
</tr>
<tr>
<td></td>
<td>Left eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Right ear</td>
<td></td>
<td></td>
</tr>
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</table>
Medication Safety

♦ Large percent of medication errors due to prescribing (20-49%)
♦ For the most part, physicians prescribe
♦ Check Look-alike Sound-alike drugs and alerts
♦ Safe medication order writing policy-
  – see pg 46 Blue book
♦ Promote physician calling near miss line
Disclosure of Unanticipated Outcomes to Patients and Families
What is an Unanticipated Outcome?

♦ A negative or unexpected result stemming from
  – A diagnostic test, medical judgment or treatment, surgical intervention, or (commission)
  – The failure to perform a necessary test, treatment, or intervention (omission)
Why Disclosure?

♦ We are our patient’s advocates
♦ Literature shows that after an unanticipated outcome, the patient and family want to know honestly what happened, and how the hospital is going to prevent future events
♦ Rebuilds trust
♦ Caregiver/Doctor relationship
Advocating Disclosure

♦ American Society for Healthcare Risk Managers
♦ Joint Council on Accreditation of Healthcare Organizations (JCAHO)
♦ American Hospital Association
♦ American Medical Association
JCAHO

Standard

RI.1.2.2

Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes.
AMA Code of Ethics

II. A physician shall uphold the standards of professionalism, be **honest** in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, **make relevant information available to patients**, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
Steps to Follow After Event

- Care for immediate needs of patient
- Preserve evidence (Medical equipment)
- Document in the medical record
- Report (Risk Management)
- Disclose
Documentation

- Document only the **facts** of what occurred and treatment rendered
- **NOT**
  - Blame
  - Subjective feelings, opinions
  - Speculation
  - Reference to “Incident report”
Adverse Event/Quality Improvement

♦ Complete & submit Adverse event/QI form
♦ Notify Risk Management
♦ FDA notification if Medical Device or Medication
♦ Begin Root Cause/FMEA analysis to examine process changes that may prevent future events
Who Will Inform the Patient?

♦ The attending physician
♦ May need pre-disclosure conference with Nursing, Risk Management
♦ All patient questions should be referred to the attending physician
When Should Disclosure Occur?

- As soon as possible after immediate needs of patient addressed
- Gather facts FIRST
- May not have all the facts yet, in which case, DON’T SPECULATE!
- Offer to speak again as facts become known
How?

- Convey compassion
  - "I am sorry for your….." "I am sorry that you…"
- Known facts
- Privacy
- No **BLAME** on any member of healthcare team
- Avoid defensive posture/reaction
- Respond to patient complaints (provide forms, contact patient advocates/ombudsman)
Health Care Worker Involved in Adverse Event

- AVOID BLAME
- Provide counseling, if needed
- Remember: No one goes to work intending to make a mistake
- Health Care Workers feel tremendous guilt after an event that harms a patient
Adverse Event Reports

Incident Occurs

Root Cause Analysis/FMEA
-Process

Peer Review
-Physician specific practice as it relates to care of this patient
Goal of Peer Review

♦ Monitor and improve physician care of patients

♦ Accomplish by:
  – Open, non-punitive discussion
  – Review and discuss alternatives
  – Disseminate to ALL physicians
    Monthly Vignettes
Near Miss/Practice Improvement

- A "near-miss", "save" or "close call" is an adverse event that could have resulted in injury but did not, because it did not reach the patient.
- Having information about "near miss" events allows S&W to improve patient care processes and patient safety. An electronic form is available on http://insite for "near-miss" event reporting.
- Residents are encouraged to report near misses. The reports are privileged and confidential.
In Summary

♦ Residents should feel free to report medical mistakes and/or near misses to their supervisors without fear of retribution.
♦ Residents should be encouraged to explain what happened to affected patients and any corrective procedure.
The End

♦ Continue to the post test
♦ Print the post test
♦ Complete the post test
♦ Return the post test to
  – Dr. Sandra Oliver
  – 407i TAMUII
Post test 1

Eliminate wrong-site, wrong-patient, wrong procedure surgery includes which of the following

A. Use a postoperative verification process to confirm that appropriate documents (e.g., medical records) are available.
B. Mark the surgical site
C. Involve the family in marking the surgical site.
Post test 2

Rewrite the following order to be in compliance with JCAHO national safety guidelines:

NTG 5.0 mg patch qd
Place in order the steps to take after an adverse event

___ Report (Risk Management)
___ Preserve evidence (Medical equipment)
___ Document in the medical record
___ Care for immediate needs of patient
___ Disclose