Why Are We Not Safer?

Frank Federico, Safety Expert, HRO Executive Coach

Mouna Ayoub Bahsoun, RN, IHIf, MSHCQ, CPPS, CPHQ

Photo by Nick Morrison on Unsplash

What emotion are you feeling today as we get ready to embark on our discussion?

Challenging

Full of opportunities

Exciting

Overwhelming

Draining

Scary

Time consuming

Something else?

Objectives

At the end of this session, you will be able to:

- Discuss our journey in patient safety
- List the fundamental steps all should take to improve patient safety
- Explore the next steps to help make care safer

Medicare Pay-for-Performance Programs Not Linked to Consistent Quality, Safety Improvements

Medicare's three hospital pay-for-performance (P4P) programs are not associated with consistent improvement in quality or patient safety measures, an AHRQ-funded study in *BMC Health Services Research* concluded. Researchers used 2007–2016 data from AHRQ's **Healthcare Cost and Utilization Project** for 14 states to identify hospital-level inpatient quality and patient safety indicators. They also found that mortality rates generally got worse over the study period. Medicare assessed $956 million in penalties in 2019 to hospitals that failed to meet benchmarks or show improvement under the Hospital Readmission Reduction Program, the Hospital-Acquired Conditions Program and the Hospital Value-Based Purchasing Program. Given the evidence of limited impact, the cost of monitoring and enforcing penalties, and potential increase in mortality, researchers concluded that the Centers for Medicare & Medicaid Services should redesign its P4P programs before continuing to expand them. Access the **abstract**.

A Just and Fair Approach

Newaygo Nurse Charged After Failing to Report Medication Error

September 1, 2022 by 9and10news Site Staff

A Newaygo nurse was charged after failing to tell a supervisor that two incorrect doses of medicine were administered to a member of the Grand Rapids Home for Veterans, according to Attorney General Dana Nessel.

The Department of the Attorney General alleges that in Dec. 2020, Beverly Bratcher, 56, of Newaygo, was working as a Licensed Practical Nurse at the Grand Rapids Home for Veterans and became aware that two incorrect medication doses were given to a member of the home.

Former Tennessee nurse **RaDonda Vaught** received a three-year supervised probation after a jury found her guilty of a fatal medical mistake. The jury in March said Vaught was guilty of criminally negligent homicide and abuse of an impaired adult after a 2017 incident in which she injected an elderly patient with a drug that led to her death.

Former Tennessee nurse re...

msn.com

Elderly woman given wrong dose of medication six times, by six different nurses

Sophie Harris14:00, Sep 05 2022

An elderly woman living at an aged care facility was given the incorrect dose of blood thinners six times, by six different nurses, over a five-month period.

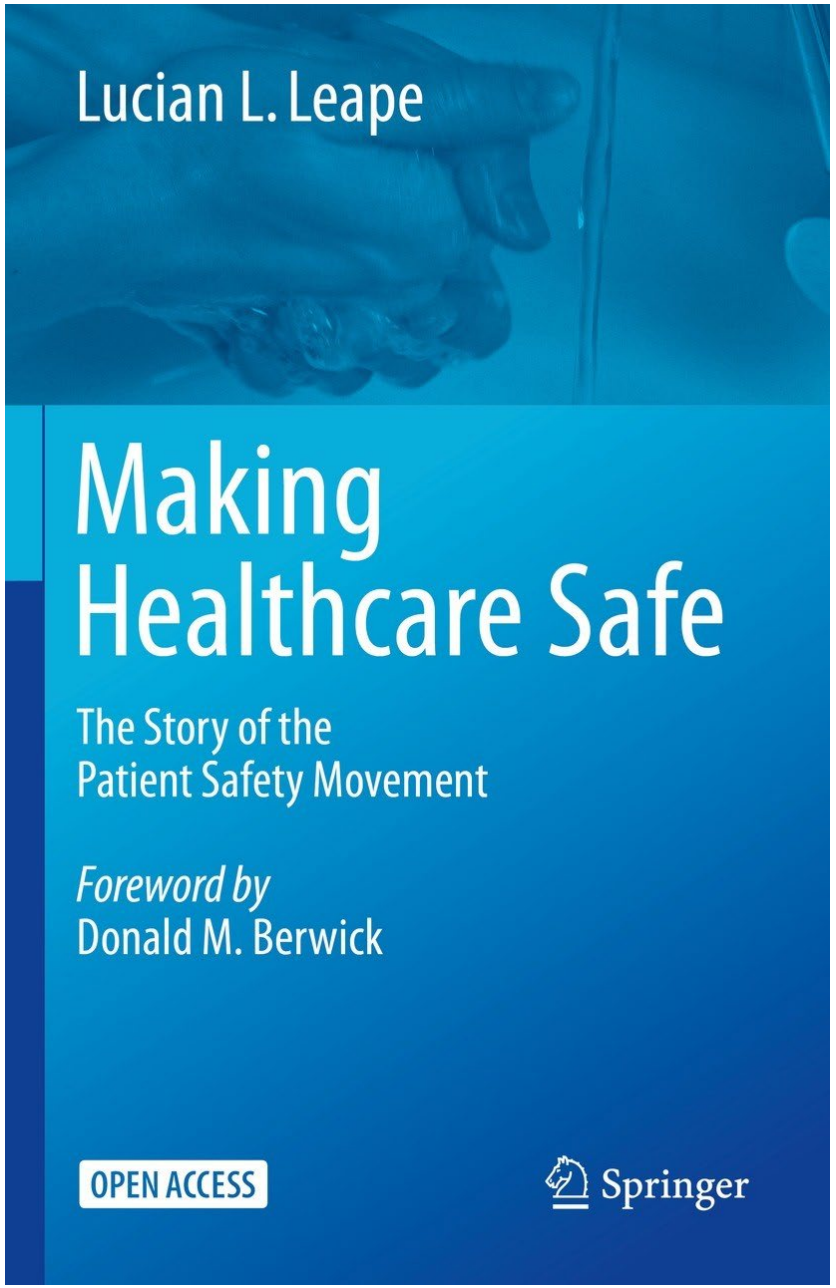
There were six occasions when 3mg of warfarin was administered instead of the 2mg charted.

There was no evidence the care facility ever undertook a formal investigation into the matter and told the HDC it could not locate the incident report.

Elderly woman given wrong dose of medication six times, by six different nurses | Stuff.co.nz

Start of the Patient Safety Movement

- Harvard Medical Malpractice Study, Leape et al. (1991)
- Chemotherapy overdose at Dana Farber Cancer Institute (1995)
- Amputation of the wrong leg in Florida (199%)
- The publication of the Institute of Medicine's (IOM) *To Err is Human* in December (1999)
- First Annenberg Center for Health Sciences in Rancho Mirage, California (1996)



Making Healthcare Safe | SpringerLink

OPEN ACCESS

Safety in healthcare is a moving target

Charles Vincent,[1] Rene Amalberti[2]

[1]Department of Experimental Psychology, University of Oxford, Oxford, UK
[2]Haute Autorité de Santé, Paris, France

Correspondence to
Professor Charles Vincent, Department of Experimental Psychology, University of Oxford, Tinbergen Building, 9 South Parks Road, Oxford OX1 3UD, UK; charles.vincent@psy.ox.ac.uk

Received 16 May 2015

Safety in healthcare is a constantly moving target. As standards improve and concern for safety grows, we come to regard an increasing number of events as patient safety issues. In this respect, healthcare differs from almost all other safety-critical industries. What we regard as harm in, for instance, civil aviation remains the same whatever advances may occur in aviation technology or practice. In contrast, innovation and improving standards in healthcare alter our conceptions of both harm

drug events in the community that cause admission to hospital, polypharmacy and general harm from overtreatment.[8] All these, in the past, might have been regretted, but now receive greater attention by being viewed under the safety umbrella.

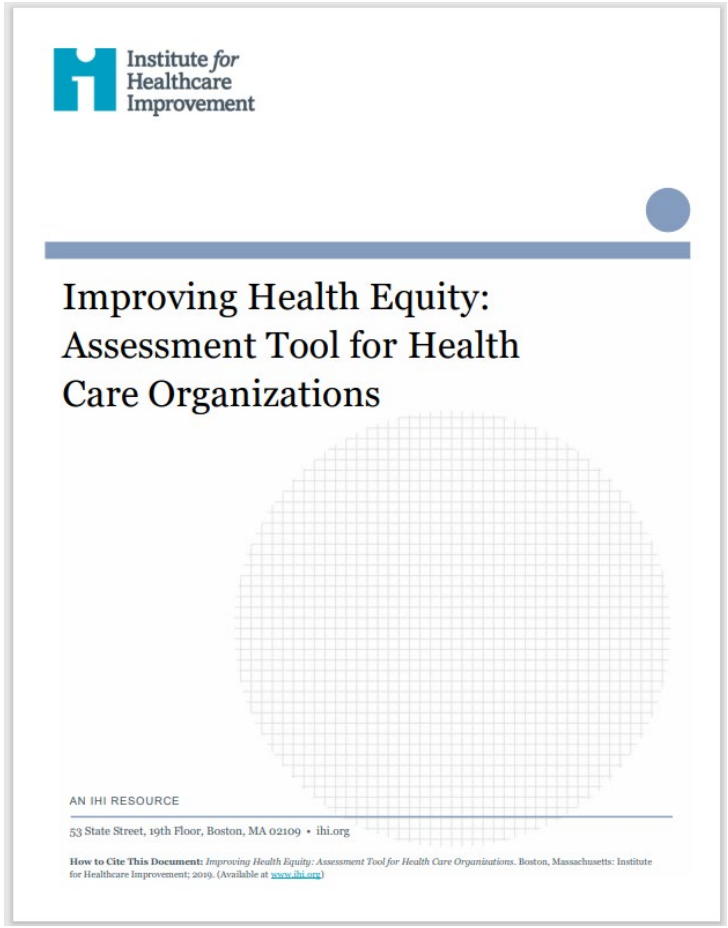
The perimeter of safety is, therefore, expanding. This is welcome for patients as it reflects rising standards and aspirations. However, the shifting perimeter does present problems, both conceptual and practical. The definition of harm

Safety is a moving target

- Focus on errors
- Focus on serious reportable events
- Focus on what the patient experiences (Harm)
- Hospital acquired conditions that can be minimized
- Diagnostic issues
- Disrespect
- Inequity
- Staff harm

Health Equity and Patient Safety:

You Can't Have One Without the Other



Home / Worker Safety in Hospitals

Worker Safety in Hospitals

Caring for our Caregivers

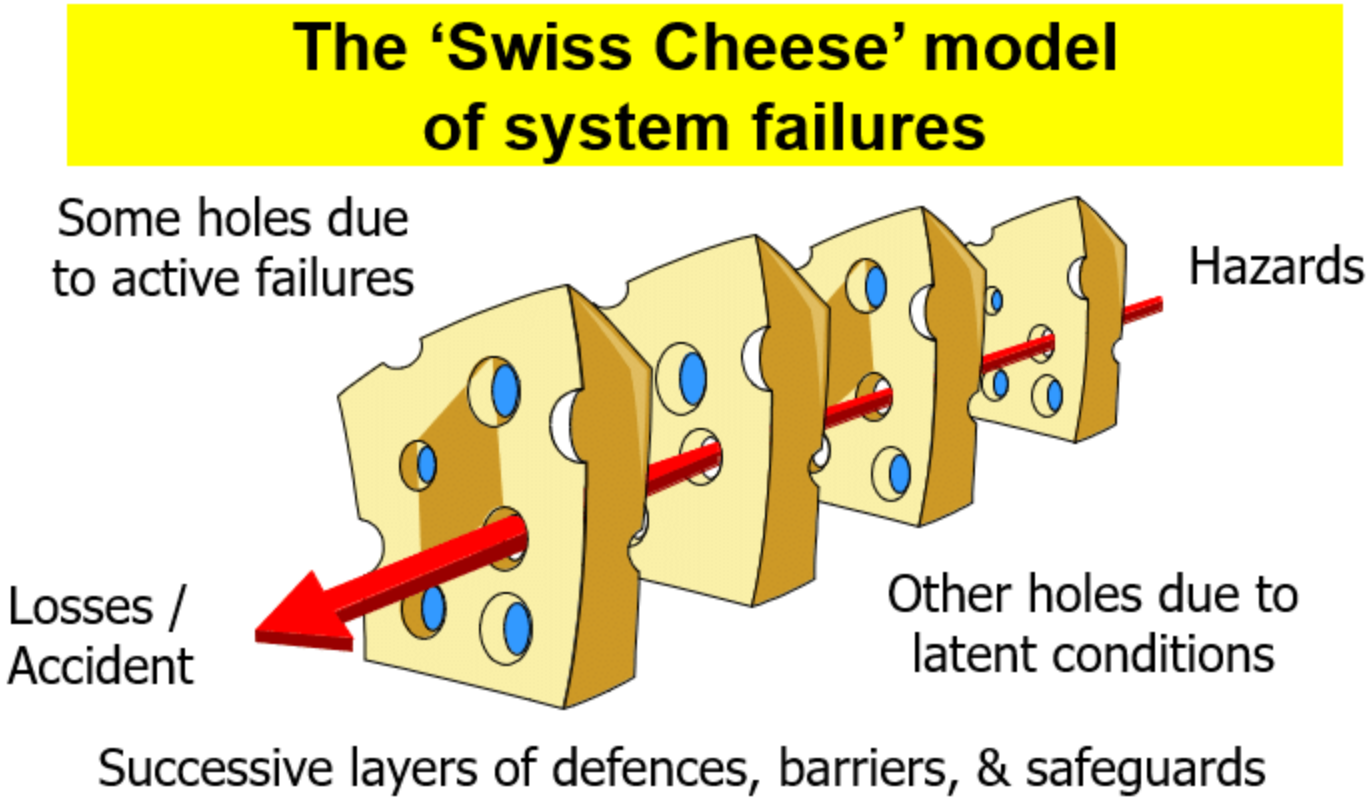
- Worker Safety in Hospitals Home
- Understanding the Problem

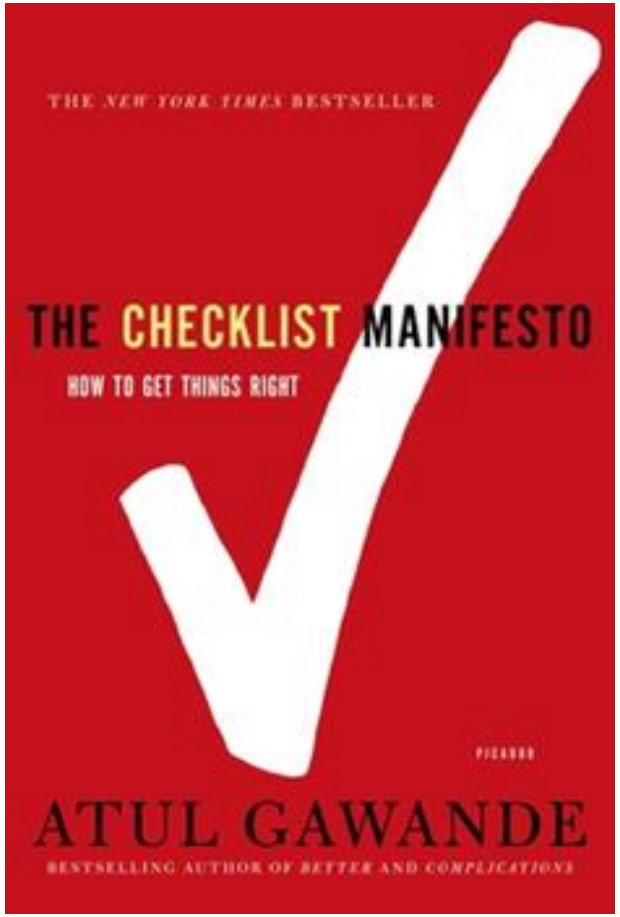
Did you know that a hospital is one of the most hazardous places to work? In 2019, U.S. hospitals recorded 221,400 work-related injuries and illnesses, a rate of 5.5 work-related injuries and illnesses for every 100 full-time employees. This is almost twice the rate for private industry as a whole.

Our Evolving Approach

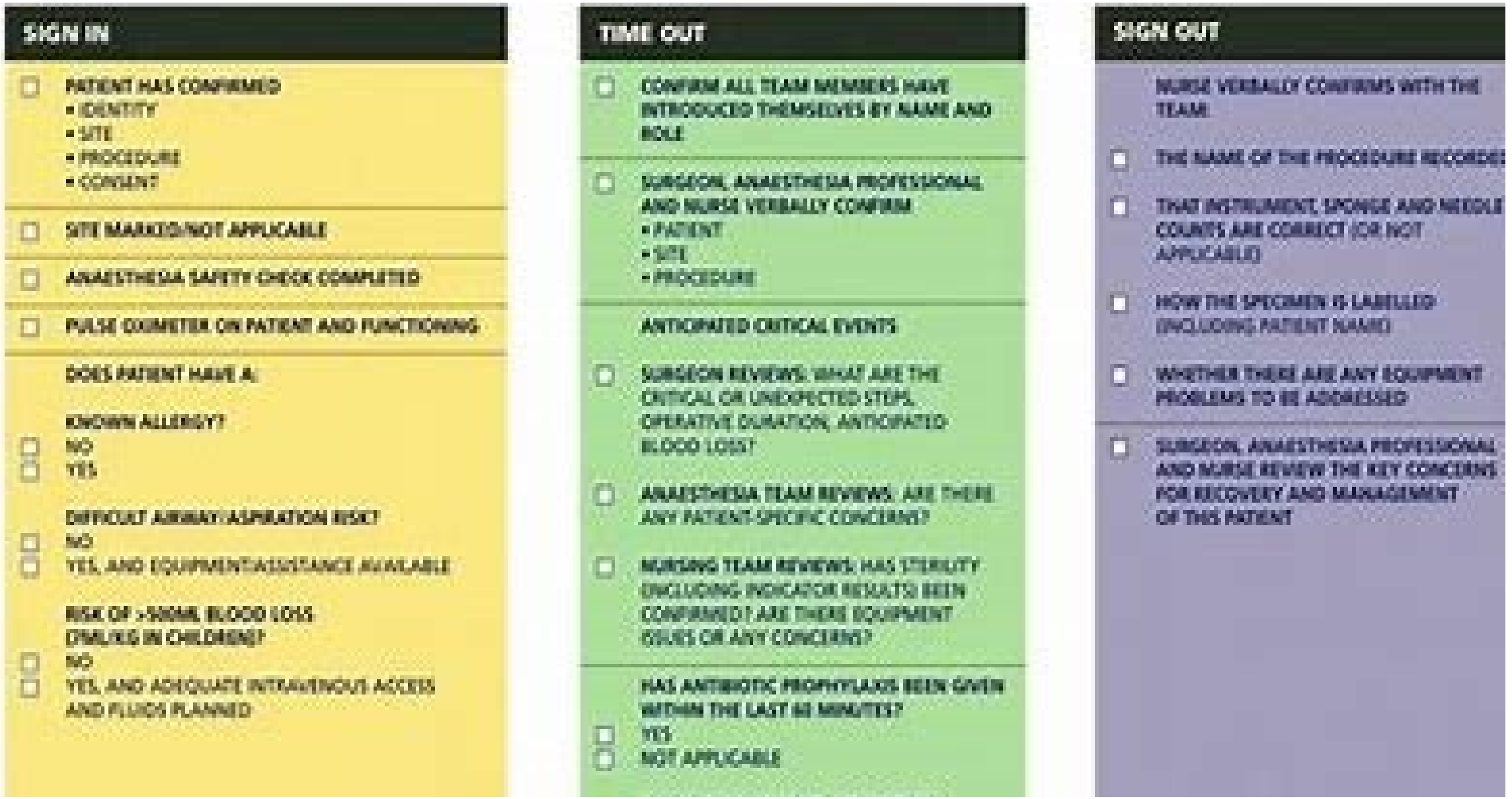
- Remove the poor performers
- Defects must be eliminated
- Develop ways to surface errors and harm and mitigate them
- Understand system issues
- Use standardization and simplification
- Develop a new process and force all areas to adopt it
- Spread will happen… we do not have a plan
- Systems will degrade over time…. We do not have a good process to determine when there is unwanted variation
- Include system engineers and human factors experts

Reason's Swiss cheese model





Checklists and Even More Checklists


SIGN IN
PATIENT HAS CONFIRMED
• IDENTITY
• SITE
• PROCEDURE
• CONSENT
SITE MARKED/NOT APPLICABLE
ANAESTHESIA SAFETY CHECK COMPLETED
PULSE OXIMETER ON PATIENT AND FUNCTIONING
DOES PATIENT HAVE A:
KNOWN ALLERGY?
NO
YES
DIFFICULT AIRWAY/ ASPIRATION RISK?
NO
YES, AND EQUIPMENT/ASSISTANCE AVAILABLE
RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
NO
YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED
TIME OUT
CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
• PATIENT
• SITE
• PROCEDURE
ANTICIPATED CRITICAL EVENTS
SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?
HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
YES
NOT APPLICABLE
SIGN OUT
NURSE VERBALLY CONFIRMS WITH THE TEAM:
THE NAME OF THE PROCEDURE RECORDED
THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

Assessments and Workload

- Fall risk assessment
- Pressure injury assessment
- Head to toe admission assessment
- Focused Nursing Assessments
- Emergency Assessments
- Med-Surg Nursing Assessments
- ICU Assessments
- Others……

“Performing a fall risk assessment on your patient should occur multiple times throughout their hospital stay.”

Spread and Sustainability of Effective Practices

"Ensure that effective practices are spread widely and deeply"

Carol Haraden

Mass standardization with local customization

The Seven *Spreadly* Sins (If you do these things, spread efforts will fail!)

Step #1 Start with large pilots

Step #2 Find one person willing to do it all

Step #3 Expect vigilance and hard work to solve the problem

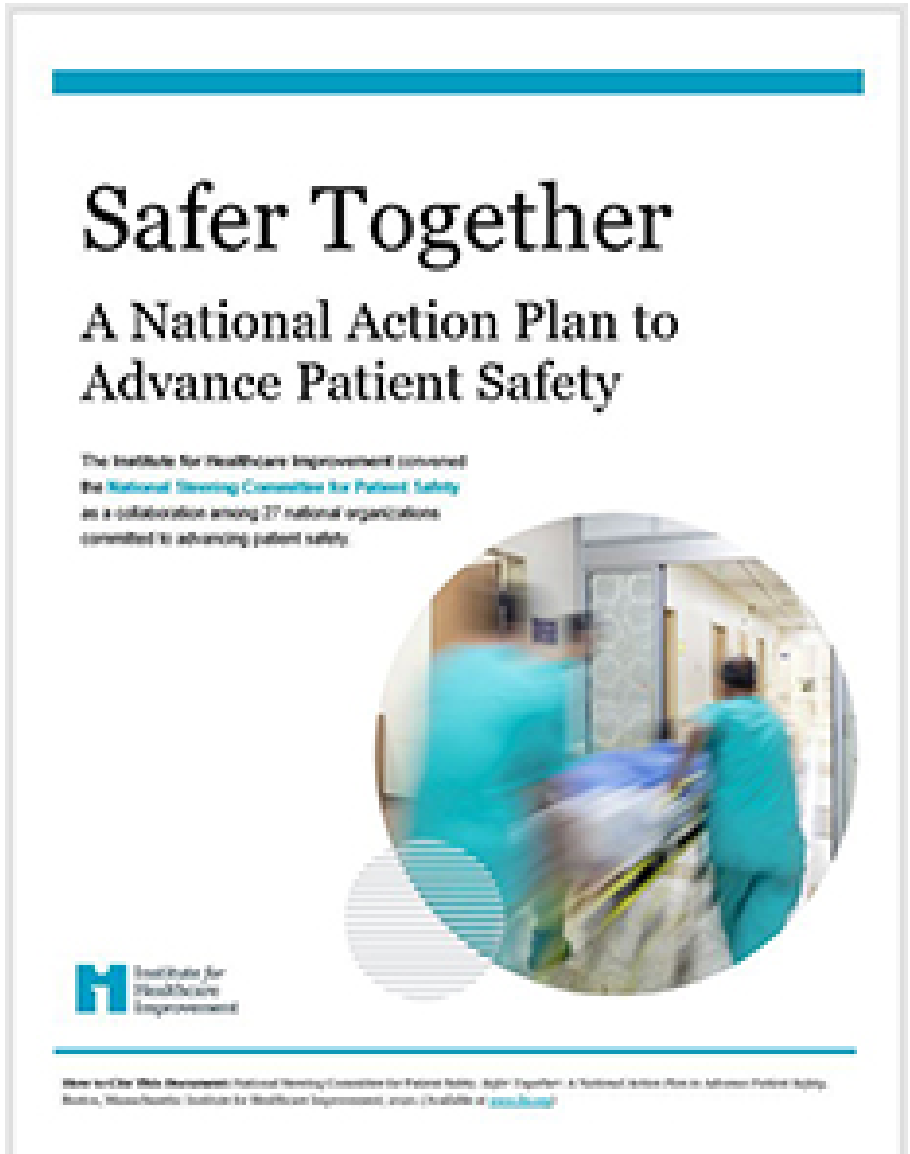
Step #4 If a pilot works then spread the pilot unchanged

Step #5 Require the person and team who drove the pilot to be responsible for system-wide spread

Step #6 Look at process and outcome measures on a quarterly basis

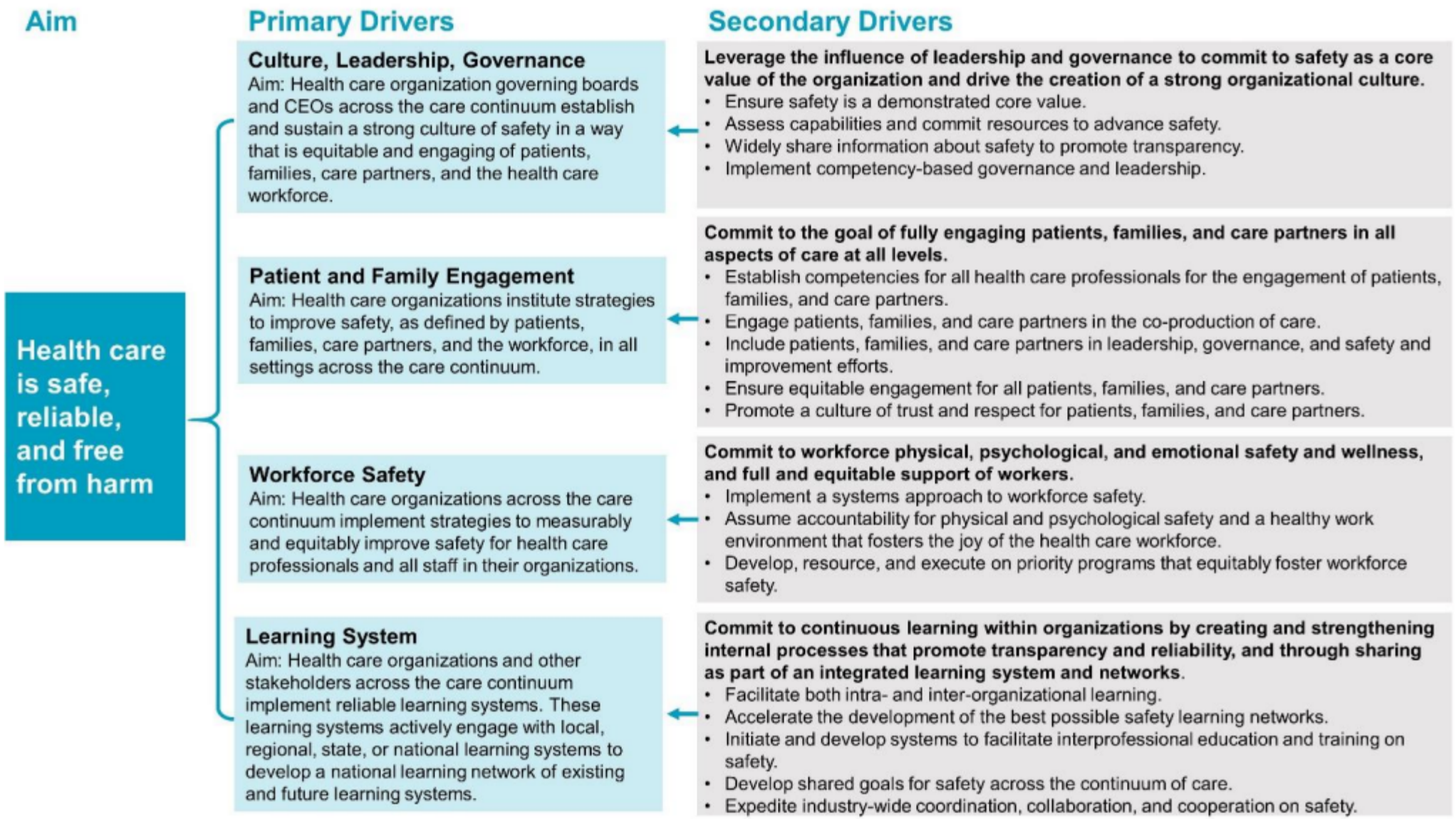
Step #7 Early on expect marked improvement in outcomes without attention to process reliability

Foundational Approaches



National Action Plan to Advance Patient Safety

- Culture, Leadership, and Governance
- Patient and Family Engagement
- Workforce Safety
- Learning System


Aim
Health care is safe, reliable, and free from harm
Primary Drivers
Culture, Leadership, Governance
Aim: Health care organization governing boards and CEOs across the care continuum establish and sustain a strong culture of safety in a way that is equitable and engaging of patients, families, care partners, and the health care workforce.
Patient and Family Engagement
Aim: Health care organizations institute strategies to improve safety, as defined by patients, families, care partners, and the workforce, in all settings across the care continuum.
Workforce Safety
Aim: Health care organizations across the care continuum implement strategies to measurably and equitably improve safety for health care professionals and all staff in their organizations.
Learning System
Aim: Health care organizations and other stakeholders across the care continuum implement reliable learning systems. These learning systems actively engage with local, regional, state, or national learning systems to develop a national learning network of existing and future learning systems.
Secondary Drivers
Leverage the influence of leadership and governance to commit to safety as a core value of the organization and drive the creation of a strong organizational culture.
• Ensure safety is a demonstrated core value.
• Assess capabilities and commit resources to advance safety.
• Widely share information about safety to promote transparency.
• Implement competency-based governance and leadership.
Commit to the goal of fully engaging patients, families, and care partners in all aspects of care at all levels.
• Establish competencies for all health care professionals for the engagement of patients, families, and care partners.
• Engage patients, families, and care partners in the co-production of care.
• Include patients, families, and care partners in leadership, governance, and safety and improvement efforts.
• Ensure equitable engagement for all patients, families, and care partners.
• Promote a culture of trust and respect for patients, families, and care partners.
Commit to workforce physical, psychological, and emotional safety and wellness, and full and equitable support of workers.
• Implement a systems approach to workforce safety.
• Assume accountability for physical and psychological safety and a healthy work environment that fosters the joy of the health care workforce.
• Develop, resource, and execute on priority programs that equitably foster workforce safety.
Commit to continuous learning within organizations by creating and strengthening internal processes that promote transparency and reliability, and through sharing as part of an integrated learning system and networks.
• Facilitate both intra- and inter-organizational learning.
• Accelerate the development of the best possible safety learning networks.
• Initiate and develop systems to facilitate interprofessional education and training on safety.
• Develop shared goals for safety across the continuum of care.
• Expedite industry-wide coordination, collaboration, and cooperation on safety.

Multi-stakeholder Approach

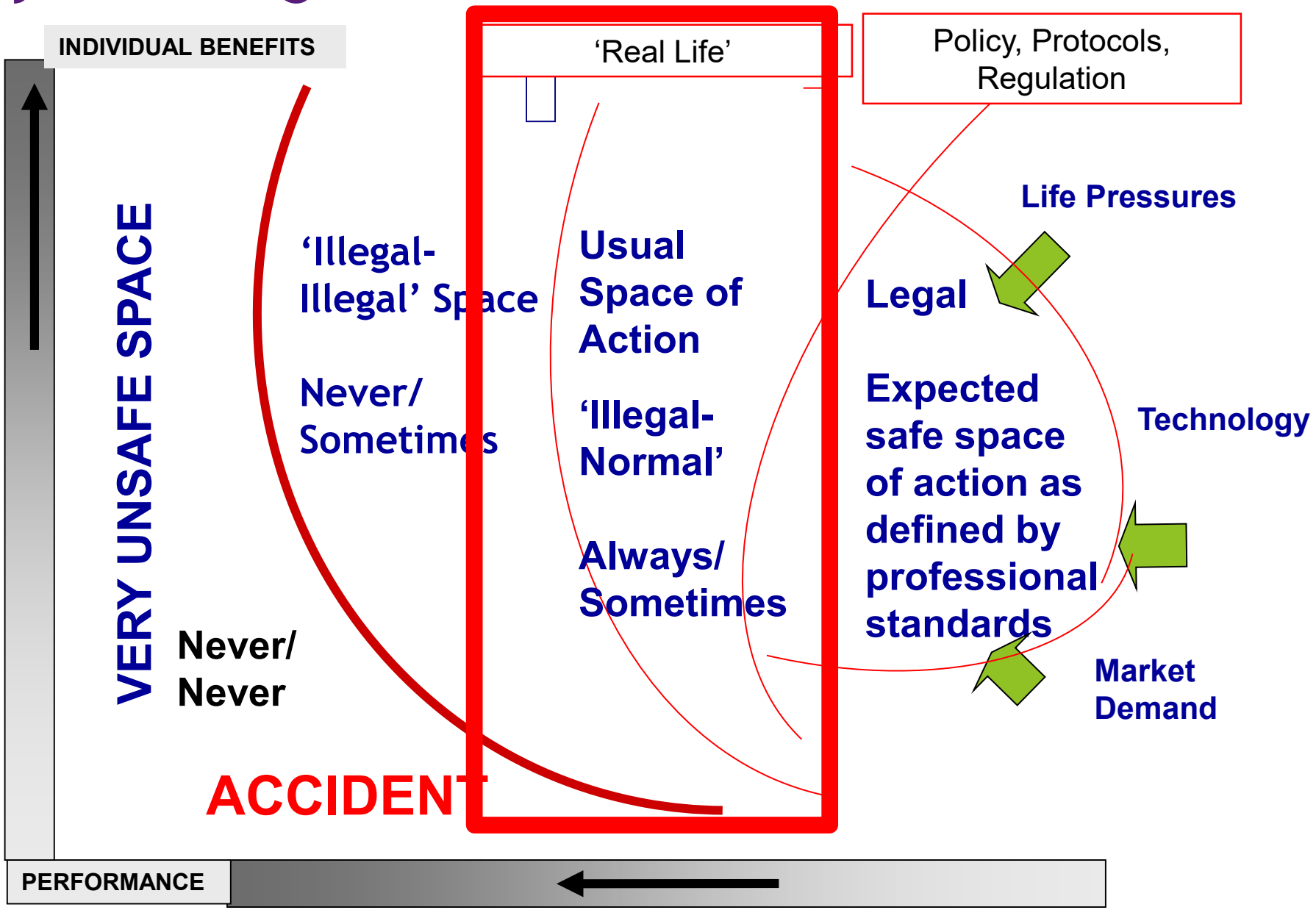
- Total systems safety requires a shift from reactive, piecemeal interventions to a proactive strategy in which risks are anticipated and system-wide safety processes are established and applied across the entire health care continuum to address them. It also requires coordination at many levels, which in turn necessitates robust collaboration among all stakeholders.
- 27 organizations involved

Autopilot

Does standardization and adherence to protocols result in:

- Deskilling
- Loss of critical thinking skills
- Performing on autopilot
- Developing workarounds

Systemic Migration to Boundaries



Amalberti

Less is More

- “Just because we can does not mean we have to”
- Giving patients choice
- “What matters to you”
- So many “ME TOO” medications
- Advances in technology

There is beauty in simplicity.

The Advent of Huddles in Healthcare

- **Short, stand-up meeting**
- **Topic: what are we worried about today?**
- **Discussion is about the known risks/concerns at that time**
- **Should last no longer than 10 minutes… 5 is even better**

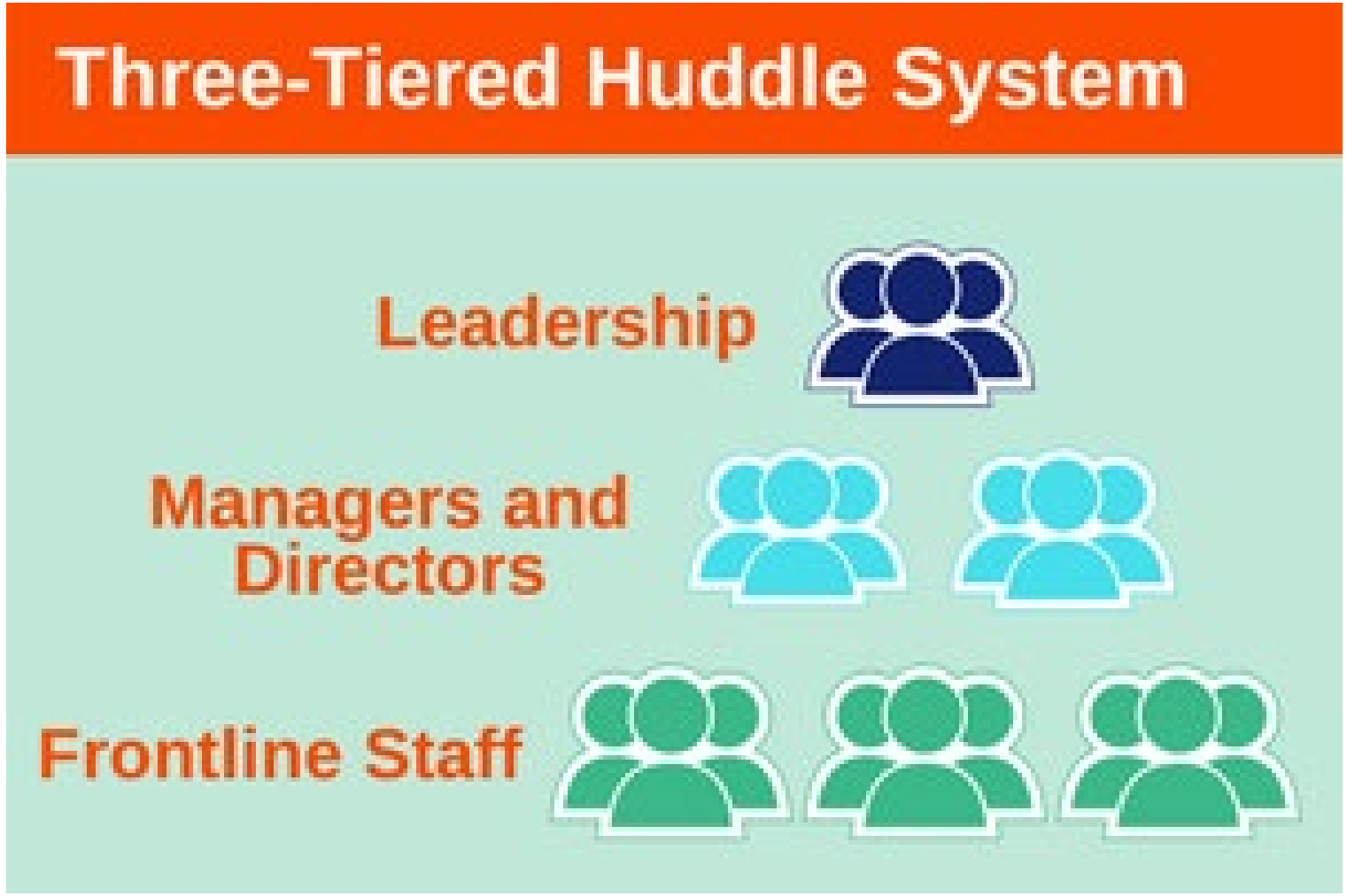


image of a tiered huddle in health care - Search (bing.com)

The Good and the Bad of Huddles

Bad

- Too long and off topic
- About anything but risks/concerns
- Because no action is taken, staff find no value
- Waste of time for all involved

Good

- Highlights risks/concerns
- Gives staff an opportunity to raise concerns
- Raises concerns up through the organization
- Action is taken to mitigate the risks

Human Factors

- Situation awareness (SA) involves being aware of what is happening around you to understand how information, events, and your own actions will impact your goals and objectives, both now and in the near future.

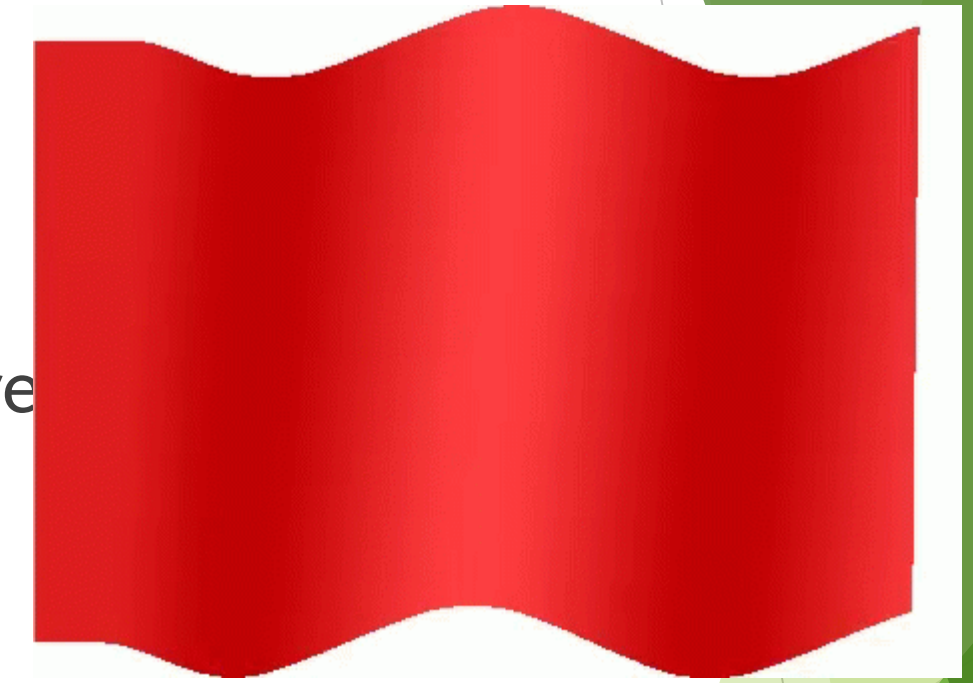
- Lacking SA or having inadequate SA has been identified as one of the primary factors in accidents attributed to human error.

What is going on in the world around us?

- How often are aware of changing conditions?
  - Driving in inclement weather
  - Walking on a dark street
  - Activity such as playing a sport

Loss of Situational Awareness

1. Ambiguity
2. Reduced/ poor communication
3. Confusion
4. Trying something new under pressure
5. Deviating from established norms
6. Verbal violence
7. Doesn’t feel right
8. Fixation / boredom / task saturation
9. Being rushed / behind schedule



What Will It Take?

- Help individuals understand what we mean by situational awareness
- Look for signs and signals
- Develop a culture of STOP THE LINE
  - Requires leadership support
  - Psychological safety
  - Teamwork and communications
  - Learning system

Would Better Situational Awareness Have Helped Prevent the Medication Administration Error?

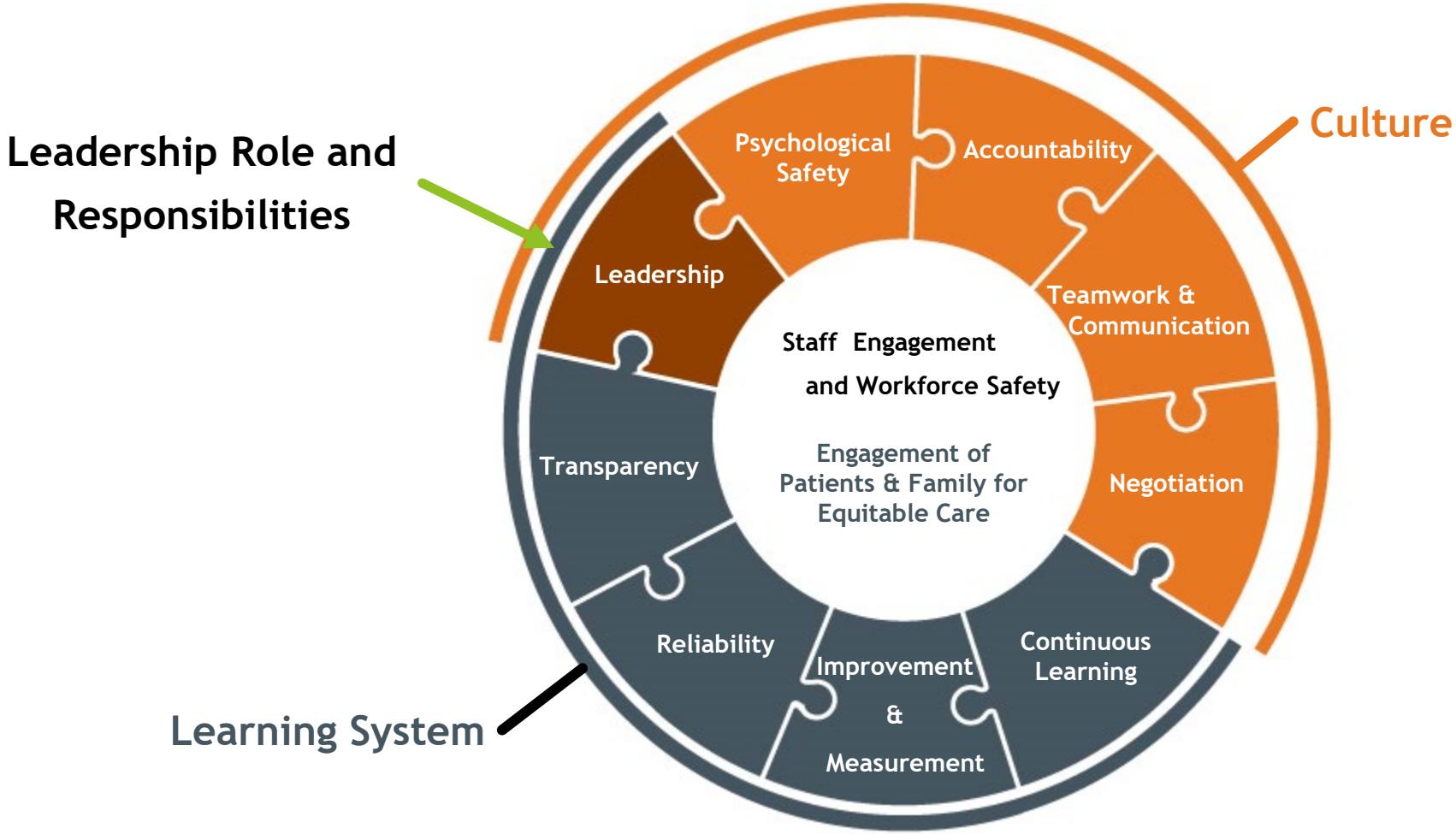
IS HRO the solution?

- **We seek to be HRO**
- **The journey is not easy**
- **HRO have a culture that enables a learning system**
- **The principles of HRO reflect a behaviors and activities**
- **Healthcare is too busy "ticking the box"**
- **Unless there is a culture change- reflected in behaviors and activities similar to HRO- we will not be any better than we are**

"Every system is perfectly designed to get the results that it gets"

Batalden/Berwick

Framework for Safe, Reliable, Equitable and Effective Care



Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Charles Vincent

Thank You

We welcome Questions/Comments