Improved Patient Care and Safety

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ARS Question #1
In my department/unit, we are actively doing things to improve patient safety

- Strongly agree
- Agree
- Neither
- Disagree
- Strongly disagree

ARS Question #2
When an event is reported, it feels like the person is being written up, not the problem

- Strongly agree
- Agree
- Neither
- Disagree
- Strongly disagree
ARS Question #3

My supervisor/manager overlooks patient safety problems that happen over and over

- Strongly agree
- Agree
- Neither
- Disagree
- Strongly disagree

ARS Question #4

Staff will freely speak up if they see something that may negatively affect patient care

- Always
- Most of the time
- Sometimes
- Rarely
- Never

ARS Question #5

When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?

- Always
- Most of the time
- Sometimes
- Rarely
- Never
Patient Safety

• Application of safety science methods toward the goal of achieving a trustworthy system of health care delivery\(^1\)
• An attribute of health care systems that minimizes the incidence and impact of adverse events and maximizes recovery from such events\(^1\)
• Patient safety is freedom from healthcare associated, preventable harm\(^2\)


Patient Safety

• World Health Organization’s World Alliance for Patient Safety
  • Surgical Unit-based Safety Program (SUSP)
  • Surgical Site Infection control in Kenya and Uganda
• WHO Safe Childbirth Checklist
  • 130 million births → 303,000 mothers, 5.3 million children die
• WHO Guidelines Safe Surgery
  • Surgical Safety Checklist
  • Pulse Oximetry Project
• Patient Safety in Robotic Surgery: SAFROS Project
• Global initiative for Emergency and Essential Surgical Care

WHO: 10 Facts on Patient Safety

1. Patient safety is a serious global public health issue
2. One in 10 patients may be harmed while in the hospital (developing nations)
3. Hospital infections affect 14 out of every 100 patients admitted
4. Most people lack access to appropriate medical devices
5. Unsafe injections decreased by 88% from 2000 to 2010
6. Delivery of safe surgery requires a teamwork approach
7. About 20-40% of all health spending is wasted due to poor-quality care
8. A poor safety record for health care
9. Patient and community engagement and empowerment are key
10. Hospital partnerships can play a critical role
Assessing the Culture of Safety in Cardiovascular Perfusion: Attitudes and Perceptions
Chad Lawson, Megan Predella, Allison Rowden, Jamie Goldstein, Joseph J. Sistino, David C. Fitzgerald
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College of Health Professions
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Survey broadcasted through email invitation (Perflist, Perfmail and LinkedIn)
37 closed, Likert-scaled questions based on AHRQ Hospital Survey on Patient Safety Culture
>75% agree or strongly agree
* “Overall work unit grade of patient safety”

Culture of Safety Highest Scoring Categories

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Question</th>
<th>Category</th>
<th>Percent &quot;Strongly agree&quot; or &quot;Agree&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A surgical team is considered before every surgical procedure</td>
<td>Staff Resilience</td>
<td>98.1</td>
</tr>
<tr>
<td>2</td>
<td>To the best of their ability, perfusion personnel are prepared</td>
<td>Feedback and communication about errors</td>
<td>98.1</td>
</tr>
<tr>
<td>3</td>
<td>The number of errors reported is frequently too low</td>
<td>Frequency of events reported</td>
<td>98.1</td>
</tr>
<tr>
<td>4</td>
<td>The hospital has an active plan to reduce errors</td>
<td>Handoffs and transitions</td>
<td>98.1</td>
</tr>
<tr>
<td>5</td>
<td>The hospital has an active plan to improve communications</td>
<td>Communication openness</td>
<td>98.1</td>
</tr>
<tr>
<td>6</td>
<td>The hospital has an active plan to improve communication</td>
<td>Feedback and communication about errors</td>
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</tr>
<tr>
<td>7</td>
<td>The hospital has an active plan to improve communication</td>
<td>Frequency of events reported</td>
<td>98.1</td>
</tr>
<tr>
<td>8</td>
<td>The hospital has an active plan to improve communication</td>
<td>Handoffs and transitions</td>
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<td>9</td>
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<td>Communication openness</td>
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<td>10</td>
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</tr>
<tr>
<td>11</td>
<td>The hospital has an active plan to improve communication</td>
<td>Frequency of events reported</td>
<td>98.1</td>
</tr>
<tr>
<td>12</td>
<td>The hospital has an active plan to improve communication</td>
<td>Handoffs and transitions</td>
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<td>Communication openness</td>
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</tr>
</tbody>
</table>

Chart 5-1. Composite-Level Average Percent Positive Response – 2014 Database Hospitals
Culture of Safety – Lowest Scoring Categories

- My employer does not want to spend money on improving patient safety. Score: 55.1
- Staff in this unit (do not) work longer hours than is best for patient care. Score: 55.1
- We get feedback about changes put into place based on event reports. Score: 50.8
- When a mistake is made that could harm the patient, does it raise the patient’s concern about their safety? Score: 50.4
- When an event is reported, it feels like the person is being written up, not the problem. Score: 50.7
- Staff (do not) worry that mistakes they make are kept in their personal file. Score: 49.3
- Staff (do not) feel like their mistakes are held against them. Score: 48.7
- When a mistake is made but is caught and corrected before affecting the patient, how often is this reported? Score: 32.4
- When a mistake is made, but has no potential to harm the patient, how often is this reported? Score: 28.9

Joint Commission - 5 Principles of a Learning Organization

- Team learning
- Shared visions and goals
- A shared mental model
- Individual commitment to lifelong learning
- Systems thinking

“Must have a fair and just safety culture, a strong reporting system, and a commitment to put data to work by driving improvement.”

http://www.jointcommission.org/assets/1/6/PSC_for_Web.pdf

How to Promote Patient Safety

- Limiting Blame
  - Fallacy: Well-trained and conscientious practitioners do not make mistakes

- Systems Thinking
  - Standardization and simplification

- Transparency and Learning
  - Sharing information about medical errors

1. Emanuel L et al. Available at: http://www.ahrq.gov
How to Promote Patient Safety

- Culture and Professionalism
  - "Collective mindfulness": High-Reliability Organizations
    - Search for and report unsafe conditions before they pose a substantial risk and when they’re easy to fix
- Accountability for Delivering Effective, Safe Care
  - Joint Commission
  - 20,000 centers accredit/certify
  - Commitment to continuous learning / Published literature
- Health Care as an Industry
  - Partnerships
  - Human factors engineering in health care

Royal College of General Practitioners - Implications of General Practice Workload

Joint Commission Standard LD.04.05

The hospital has an organization-wide, integrated patient safety program

- This standard describes a safety program that integrates safety priorities into all processes, functions, and services within the hospital, including patient care, support, and contract services. It addresses the responsibility of leaders to establish a hospital-wide safety program, to proactively explore potential system failures, to analyze and take action on problems that have occurred, and to encourage the reporting of adverse events and near misses, both internally and externally. The hospital’s culture of safety and quality supports the safety program.
- At least every 18 months, the hospital selects one high risk process and conducts a proactive risk assessment.
- At least once a year, the hospital provides governance with written reports on all actions taken to improve safety, both proactively and in response to actual occurrences.
Identifying Risks

- Incident reports
- Near-miss reports
- Environmental tours
- Issues reported by Patient Safety Officer
- Observations by staff members
- Publications
- New regulatory issues
- Joint Commission Sentinel Events
- Product recalls
- Audits, inspections
- Industry Standards and Guidelines
- Simulation exercises
- Time-outs, briefings, debriefings
- Failure Mode & Effect Analysis (FMEA)

Summary

Aggregation of Marginal Gains

- 1% improvement
- 1% decline

Diagram: Aggregation of Marginal Gains