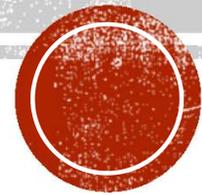


IMPORTANCE OF PATIENT SAFETY IN HOSPITAL CARE

Dr. Myo Myint Aung, M.B.,B.S, MBA, MHA, PMP

Executive Director

Vantage Health Solutions

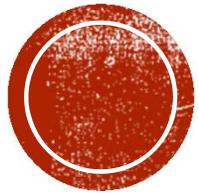


OBJECTIVES

- To provide an overview of patient safety in hospital care
- To understand how to create a culture of safety in the hospital
- To design and implement patient safety program in the hospital

OUTLINE

- Fundamentals of Patient Safety
- How to improve patient safety at the hospital
 - Root Cause and System Analysis
 - Teamwork and Communication
 - Communicating with Patients after adverse events
 - Creating culture of safety
- Way Forward



FUNDAMENTALS OF PATIENT SAFETY



THE STORY

- Two preemies in our NICU received 10x the dose of heparin
 - Drug was in similar vials
 - Used to flush the catheters to prevent clotting
- No immediate adverse events from the error

NEAR MISS



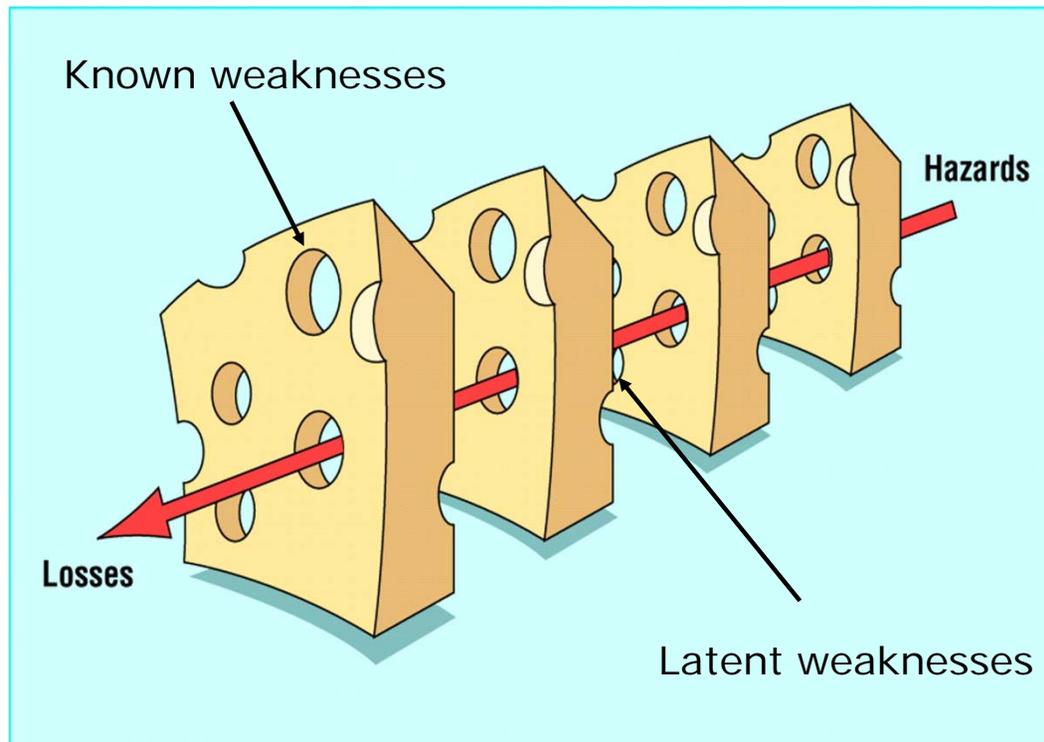
Thomas Boone & Zoe Grace

QUESTIONS

When do we tend to make errors in hospital?

If an error does not cause harm to a patient, should we report them to hospital leadership?

DESIGN PROCESSES THAT MAKE IT EASY FOR PEOPLE

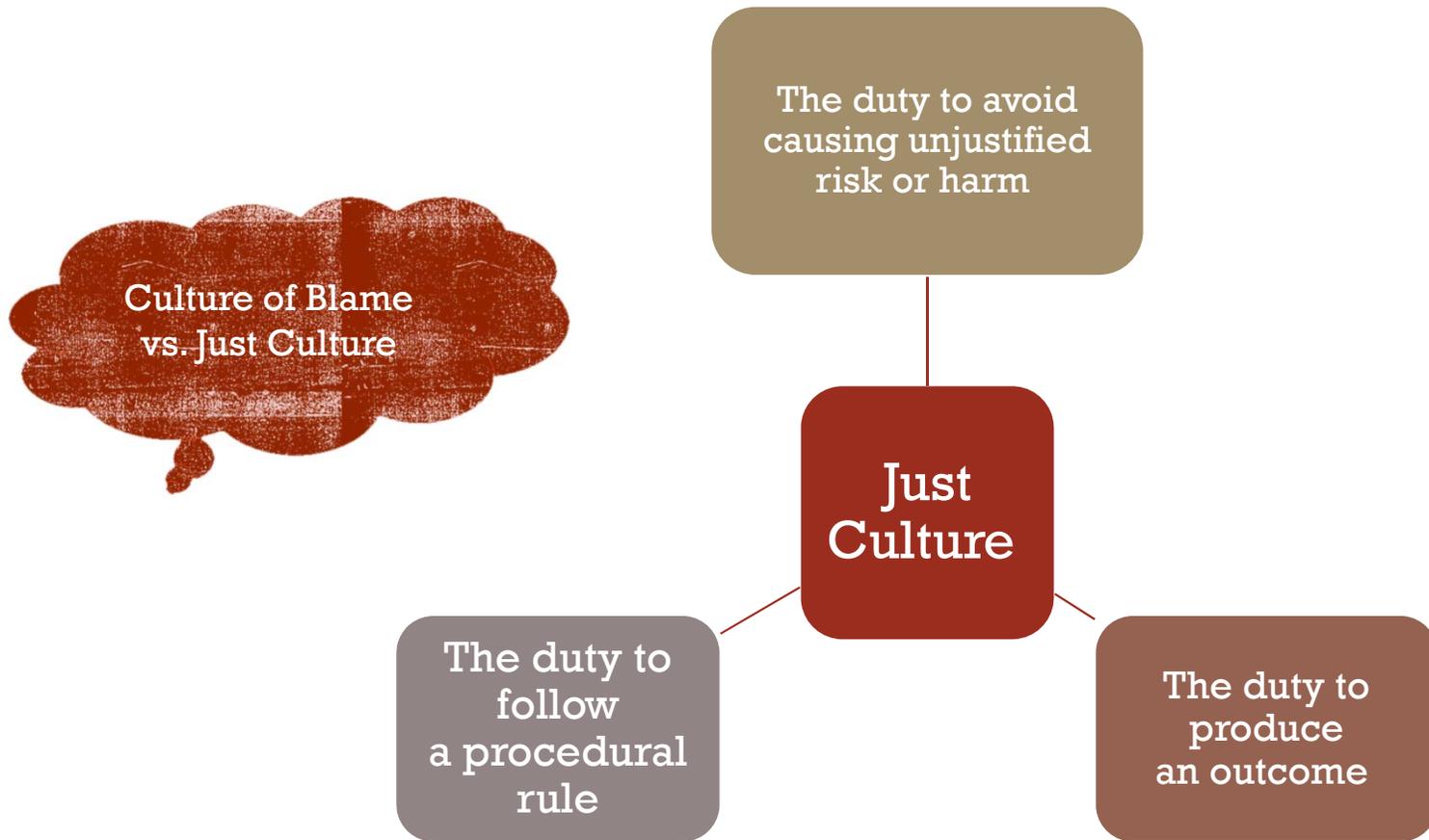


Swiss cheese model of system failure

- Distraction
- Autonomy desires
- Non standardization
- Inadequate processes
- Unanticipated events
- Schedule changes
- Random noise
- Communication
- Arrogance
- Cognitive errors
- Perceptual errors
- Busting the rules
- Being 'creative'
- Not admitting failure was a possibility

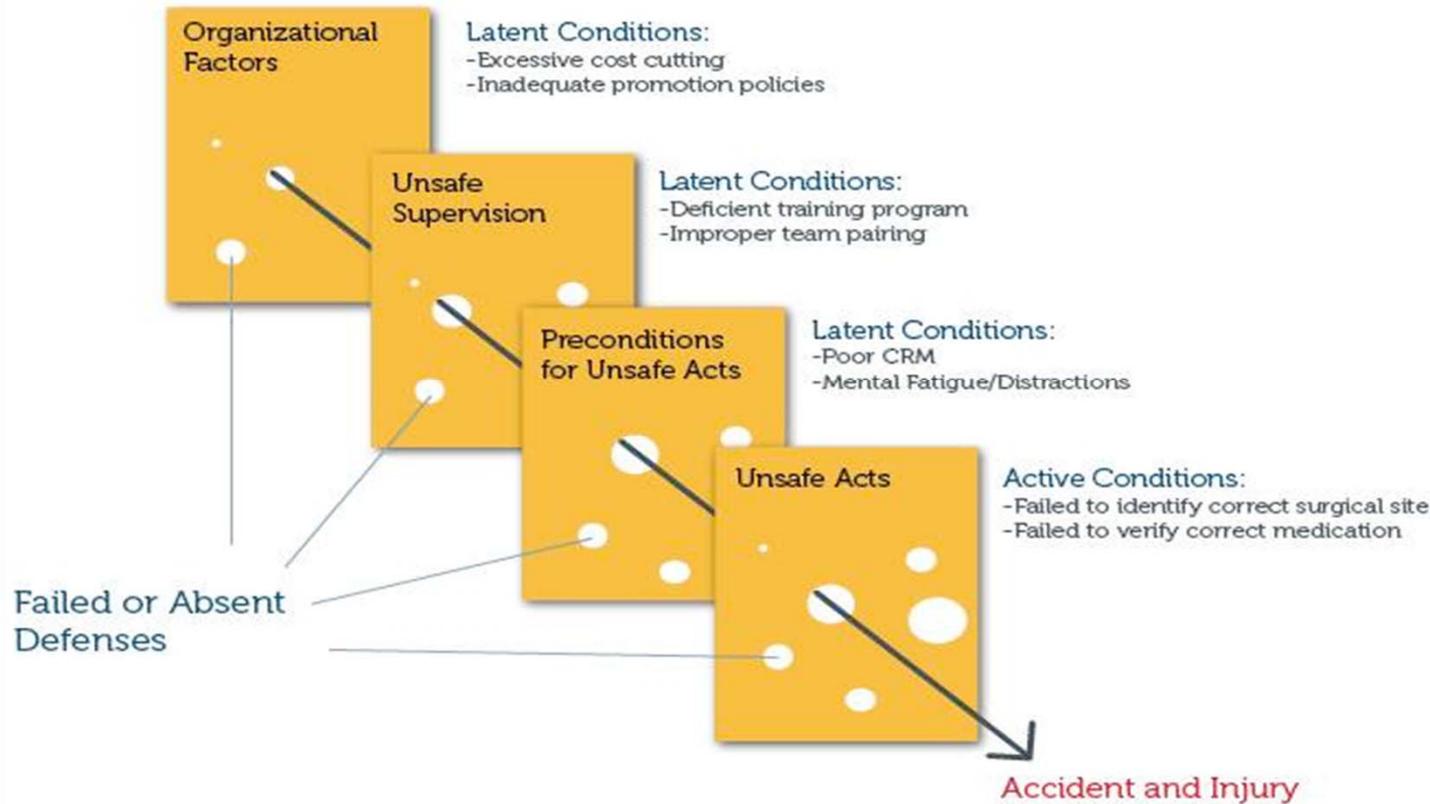
Reason, J. BMJ 2000;320:768-770

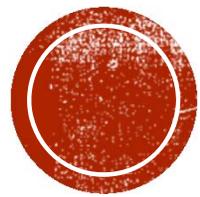
HOW WOULD YOU RESPOND TO ERROR?



IDENTIFYING AND REPORTING ERRORS

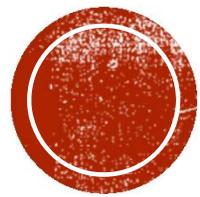
- Error = Opportunity
- Voluntary Reporting System
- Learning & Performance Improvement





HOW TO IMPROVE PATIENT SAFETY AT YOUR HOSPITAL





ROOT CAUSE AND SYSTEM ANALYSIS



CASE STUDY

CASE STUDY

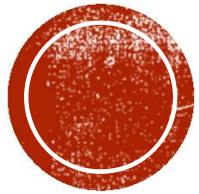
- Review the case of Margaret and;

In a Group of Four;

1. Identify what happened
2. Determine what should have happened
3. Determine causes (Ask 5 WHYs?)
4. Develop causal statement
5. Generate a list of recommended actions
6. Summarize and share in plenary discussion

ROOT CAUSE ANALYSIS (RCA) HELPS!

- RCA are retrospective
- Not appropriate in negligence or willful harm
- Accidents in health care almost never stem from a single cause



TEAMWORK AND COMMUNICATION



QUESTIONS

Share an example of a medical error caused by communication challenges?

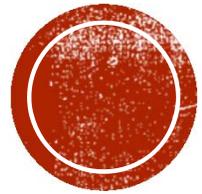
What communication tools should we use to improve teamwork in hospitals?

BASIC TOOLS AND TECHNIQUE

- Briefings & Debriefing
- SBAR: Situation, Background, Assessment, Recommendation
- Critical language
- Psychological safety

FOCUS DURING TIMES OF TRANSITIONS

- Ineffective handoffs can increase likelihood of error or patient harm.
- **Verbal repeat back**
 - Sender concisely states info. to receiver
 - Receiver then repeats back what he or she heard
 - Sender acknowledges that the repeat back was correct
 - Continue process until participants verify a shared understanding



COMMUNICATING WITH PATIENTS AFTER ADVERSE EVENTS



CASE STUDY

CASE STUDY

- Review the case of “On Being Transparent”;

You are the SMO and a patient in your hospital dies from a medication error.

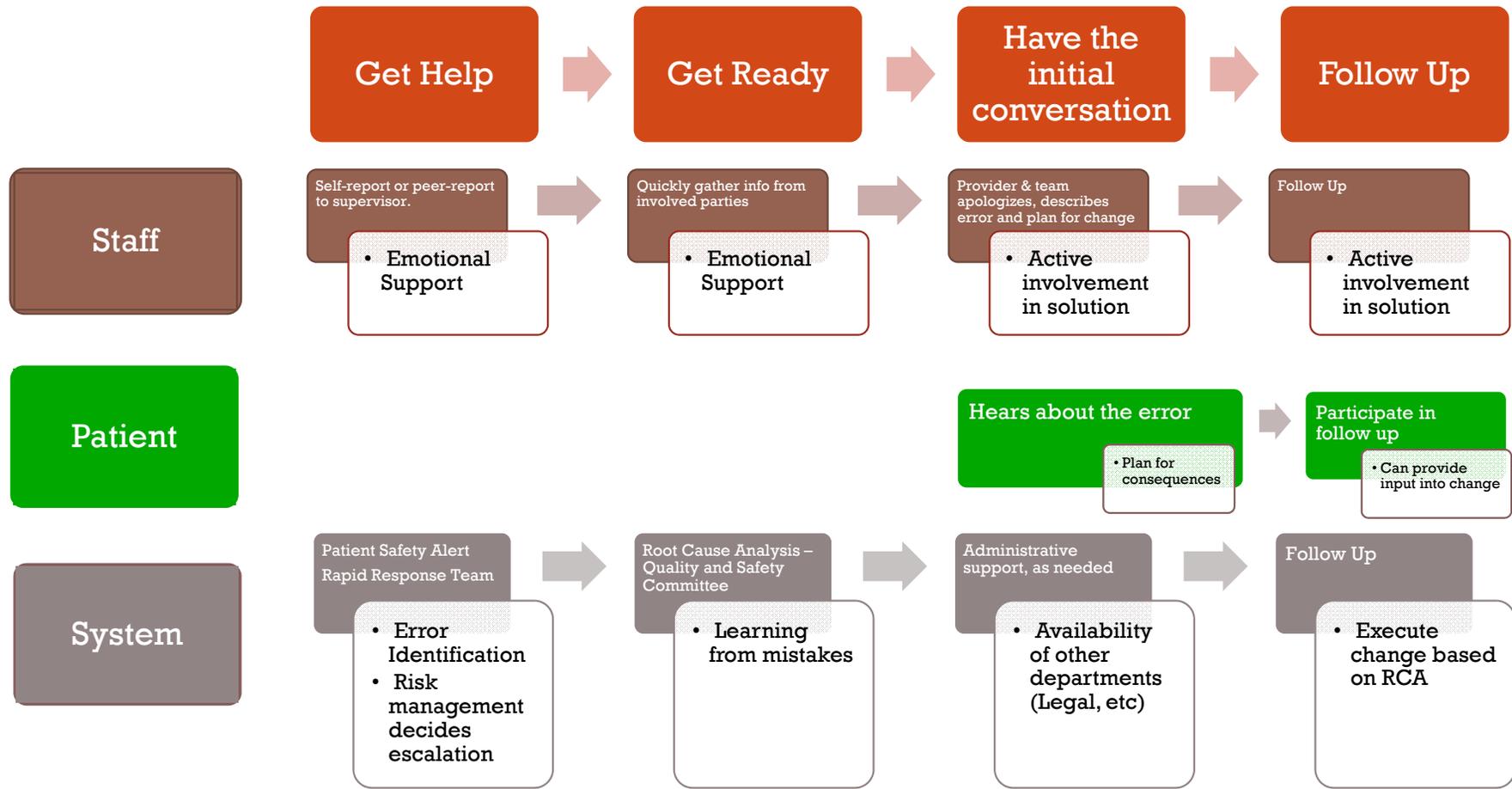
- Have you ever made or observed an error involving a patient? Was the patient harmed? How did you handle the error?

WHEN PATIENT SAFETY FAILS...

- **ERROR DISCLOSURE**
 - Improves patient satisfaction
 - Reduces risk of malpractice litigation
 - Helps us learn and improve
 - Is the **RIGHT** thing to do!



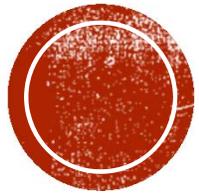
JOURNEY OF ERROR DISCLOSURE



IMPACT OF ADVERSE EVENTS ON CAREGIVERS

Upset, guilty, self-critical, depressed, and scared –
after an adverse event

1. Identify suffering
2. Provide ongoing emotional support from peers
3. Coordinate with event response to include gossip control
4. Invite second victims to become members of event related improvement team



CREATING CULTURE OF SAFETY

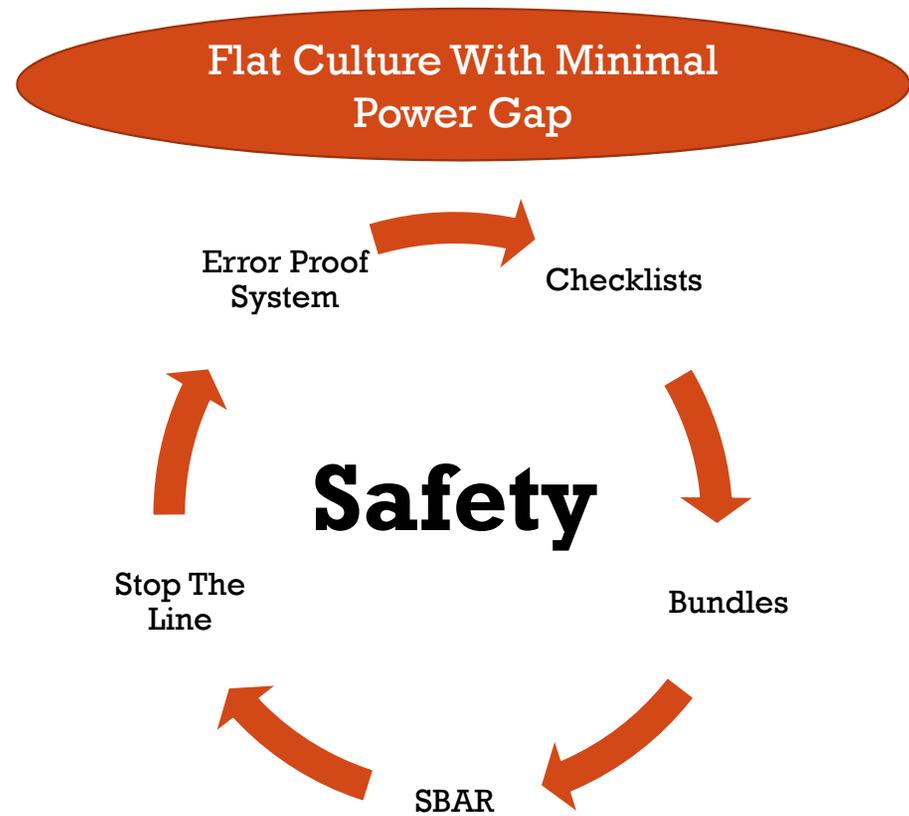


QUESTIONS

The behavior of a senior surgeon to put your patients at risk. What would you do?

Can you think of any situations when you would stay quiet when you noticed a superior providing unsafe care at your hospital?

CULTURE OF PATIENT SAFETY



JUST CULTURE

Human Error	At-Risk Behavior	Reckless Behavior
<p><i>Product of Our Current System Design and Behavioral Choices</i></p> <p>Manage through changes in:</p> <ul style="list-style-type: none">• Choices• Processes• Procedures• Training• Design• Environment	<p><i>A Choice: Risk Believed Insignificant or Justified</i></p> <p>Manage through:</p> <ul style="list-style-type: none">• Removing incentives for at-risk behaviors• Creating incentives for healthy behaviors• Increasing situational awareness	<p><i>Conscious Disregard of Substantial and Unjustifiable Risk</i></p> <p>Manage through:</p> <ul style="list-style-type: none">• Remedial action• Punitive action
Console	Coach	Punish

IMPLEMENTING JUST CULTURE

COMMUNICATE IT

- Raise Awareness
 - Introduce "near miss" stories at meetings
- Modify policies/procedures

CONVERT TO IT

- Hire to the culture
- Identify staff champions
- Maintain staff training
 - Orientation, Performance Evaluations, Monthly Dept. Reviews, etc.

SAFETY CULTURE DIAGNOSTIC ASSESSMENT

CASE STUDY

**Safety Climate Assessment
Using AHRQ safety culture survey tool**

**Serious Safety Event Rate (SSER)
baseline is calculated**

**Common Cause Analysis (CCA)
of past safety events (IRIS etc)**

Safety Governance Assessment

**Diagnostic
Assessment**

SAFETY CULTURE DIAGNOSTIC ASSESSMENT

CASE
STUDY

Serious Safety Event Rate (SSER)
baseline calculation

Serious Safety Event Rate:

A volume-adjusted measure of Serious Safety Events that provides a standardized reliable lagging indicator of organization's effectiveness in detection, correction, and prevention of harmful events to patients

Diagnostic
Assessment



SAFETY EVENT CLASSIFICATION

CASE
STUDY

A deviation from generally accepted performance standards (GAPS) that...

Serious Safety Event

- Reaches the patient *and*
- Results in moderate harm to severe harm or death

SEC Safety Event Classification

SM



Serious Safety Events

Precursor Safety Event

- Reaches the patient *and*
- Results in minimal harm or no detectable harm

Precursor Safety Events

Near Miss Safety Event

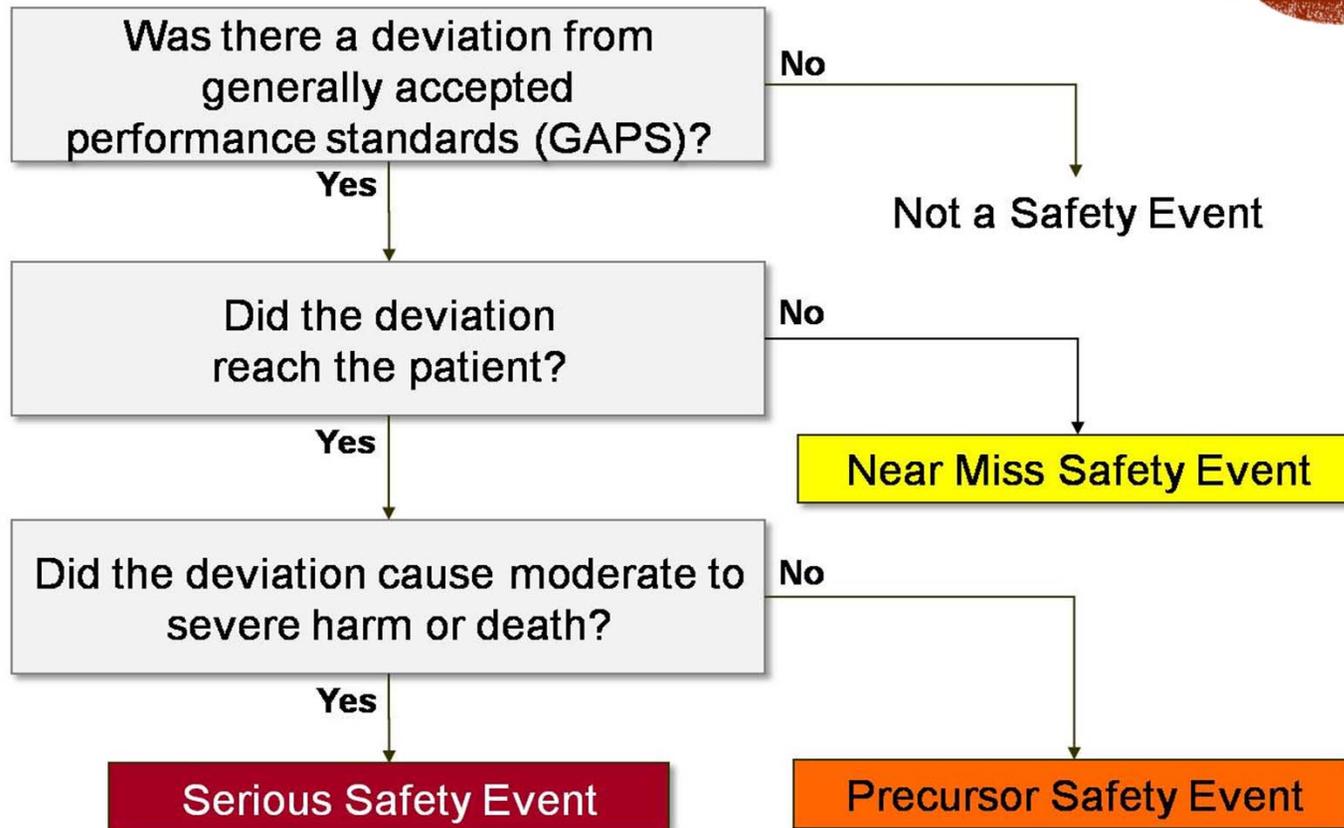
- Does not reach the patient
- Error is caught by a detection barrier or by chance

Near Miss Safety Event



SAFETY EVENT DECISION ALGORITHM

CASE STUDY



CASE STUDY



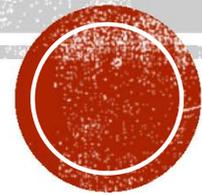
SAFETY HUDDLE

Standard Agenda

- Patient schedule for the day
- Any potential obstacles
- Special incidence
- Staffing for the day
- Improvement opportunities
- Staff time to share future improvement ideas

TO ERR IS HUMAN

How do we get things moving?



QUESTIONS

Why we are not moving towards a culture of safety at the hospital?

How do we get things moving?

WE KNOW WHY THINGS NOT CHANGING

- Denial
- Comfort in existing habits
- Ignorance of the crisis
- Competing commitments
- Ownership failures
- Human nature (what we value)
- Human factors (how we really perform)
- Normalization of deviance
- Self-interested pressures to keep current system
- Poor leadership

HOW DO WE GET THINGS MOVING?

1. Take passionate, committed, personal responsibility
2. Defeat competing commitments
3. Learn all you can about high reliability
4. Understand deeply human factors and human nature
5. Motivate people to change
6. Worship data and drive to outcomes
7. Learn more about how systems work
8. Use change models

1. SAFETY BEGINS WITH YOU

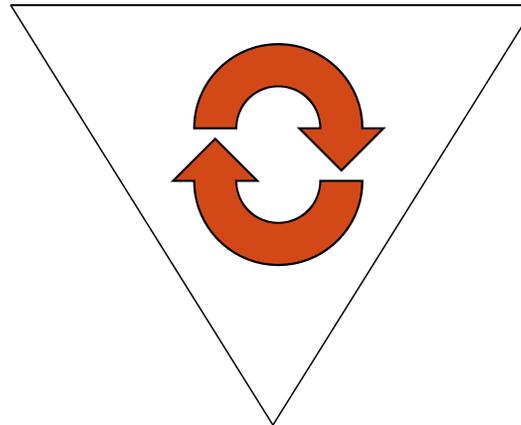
Commit now, or you're
just part of the problem



THE THREE INGREDIENTS FOR LEADERSHIP IN PATIENT SAFETY

Passionate
Preparation

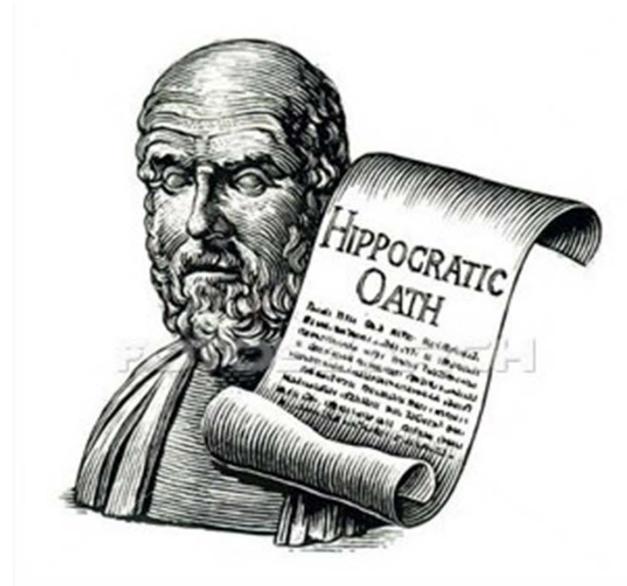
Knowledge &
Resources



Unrelenting
Execution

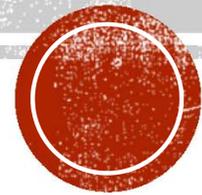
STAND, RAISE YOUR HAND AND TAKE THE OATH

“I hereby renew my commitment to do no harm to my patients, and I promise to lead my colleagues in the creation of an environment that prevents harm to all our patients.”



2. DEFEAT COMPETING COMMITMENTS

Your system is designed to do what it is currently doing, and your colleagues are deeply committed to keeping it that way





Every system is perfectly designed
to produce just the results it
produces.

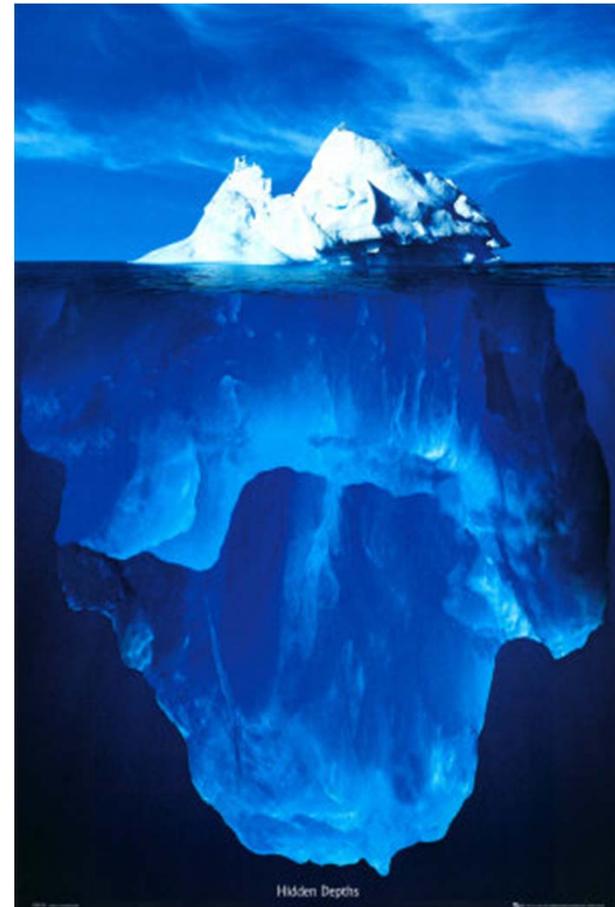
But why, and how do you change it?

COMPETING COMMITMENTS



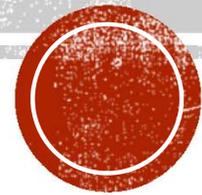
“When people resist change, it’s not necessarily because they’re opposed to it. It’s not even necessarily because they’re lazy or inattentive to it, either. Rather, it’s because they have one or more hidden beliefs that directly conflict with them working toward meaningful change.”

The Real Reason People Won’t Change:
Robert Kegan And Lisa Laskow Lahey,
Harvard Business Review



3. LEARN ABOUT HIGH RELIABILITY

Standardize everything and
everyone you can



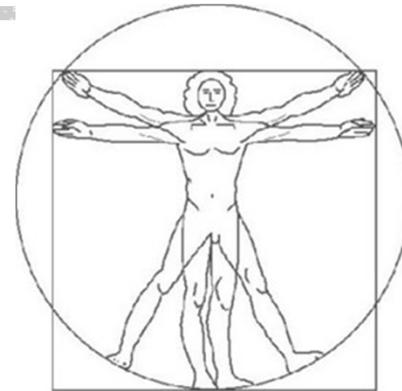
THE NEED FOR HIGH RELIABILITY

- Reliability – the degree to which an action or test produces a consistent result
 - In CQI language: *Doing things right*
- Precision – whether or not the correct result was achieved
 - In CQI language: *Doing right things*

A high reliability process consistently achieves the correct outcome

4. HUMAN FACTORS AND SAFETY

We are wired to detect change in the environment and then to do everything we can to oppose it.



START BY DEFEATING THE MYTHS

- “Quality costs too much”
- “It’s too subjective to measure”
- “It’s not my job”
- “We’ve always done it this other way”
- “Patient care is a craft not a production line”
- “My patient care is already above average”
- “My patients are just sicker”

RESPONSE CHOICES



- Reduce speed
- Not reduce speed
 - Distracted by another stimulus
 - Inattentive (spaced out)
 - Have valid reason to go faster
 - “Car doesn’t go that speed”
 - “Everybody else is speeding”
 - “You’re not the boss of me”



SYSTEM DESIGN CHANGES

- Simplify
- Standardize
- Forcing functions and constraints
- Use redundancies
- Avoid reliance on memory
- Take advantage of habits and patterns
- Promote effective team functioning
- Automate carefully

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ▶▶▶▶▶▶▶▶▶▶ Before skin incision ▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶▶ Before patient leaves operating room

SIGN IN	
<input type="checkbox"/>	PATIENT HAS CONFIRMED • IDENTITY • SITE • PROCEDURE • CONSENT
<input type="checkbox"/>	SITE MARKED/NOT APPLICABLE
<input type="checkbox"/>	ANAESTHESIA SAFETY CHECK COMPLETED
<input type="checkbox"/>	PULSE OXIMETER ON PATIENT AND FUNCTIONING
DOES PATIENT HAVE A:	
KNOWN ALLERGY?	
<input type="checkbox"/>	NO
<input type="checkbox"/>	YES
DIFFICULT AIRWAY/ASPIRATION RISK?	
<input type="checkbox"/>	NO
<input type="checkbox"/>	YES, AND EQUIPMENT/ASSISTANCE AVAILABLE
RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?	
<input type="checkbox"/>	NO
<input type="checkbox"/>	YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT	
<input type="checkbox"/>	CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
<input type="checkbox"/>	SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM • PATIENT • SITE • PROCEDURE
ANTICIPATED CRITICAL EVENTS	
<input type="checkbox"/>	SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
<input type="checkbox"/>	ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
<input type="checkbox"/>	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?	
<input type="checkbox"/>	YES
<input type="checkbox"/>	NOT APPLICABLE
IS ESSENTIAL IMAGING DISPLAYED?	
<input type="checkbox"/>	YES
<input type="checkbox"/>	NOT APPLICABLE

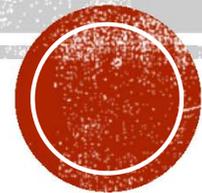
SIGN OUT	
NURSE VERBALLY CONFIRMS WITH THE TEAM:	
<input type="checkbox"/>	THE NAME OF THE PROCEDURE RECORDED
<input type="checkbox"/>	THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
<input type="checkbox"/>	HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
<input type="checkbox"/>	WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
<input type="checkbox"/>	SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT



THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

5. MOTIVATE PEOPLE TO CHANGE

The only constant is change
– help people get used to
it.



POSITIVE DEVIANCE

- Community invites change
- Community defines problem
- PDs are identified by observation and data
- Discovery of uncommon but effective practices
- Program design
- Monitoring and evaluation
- Scaling up

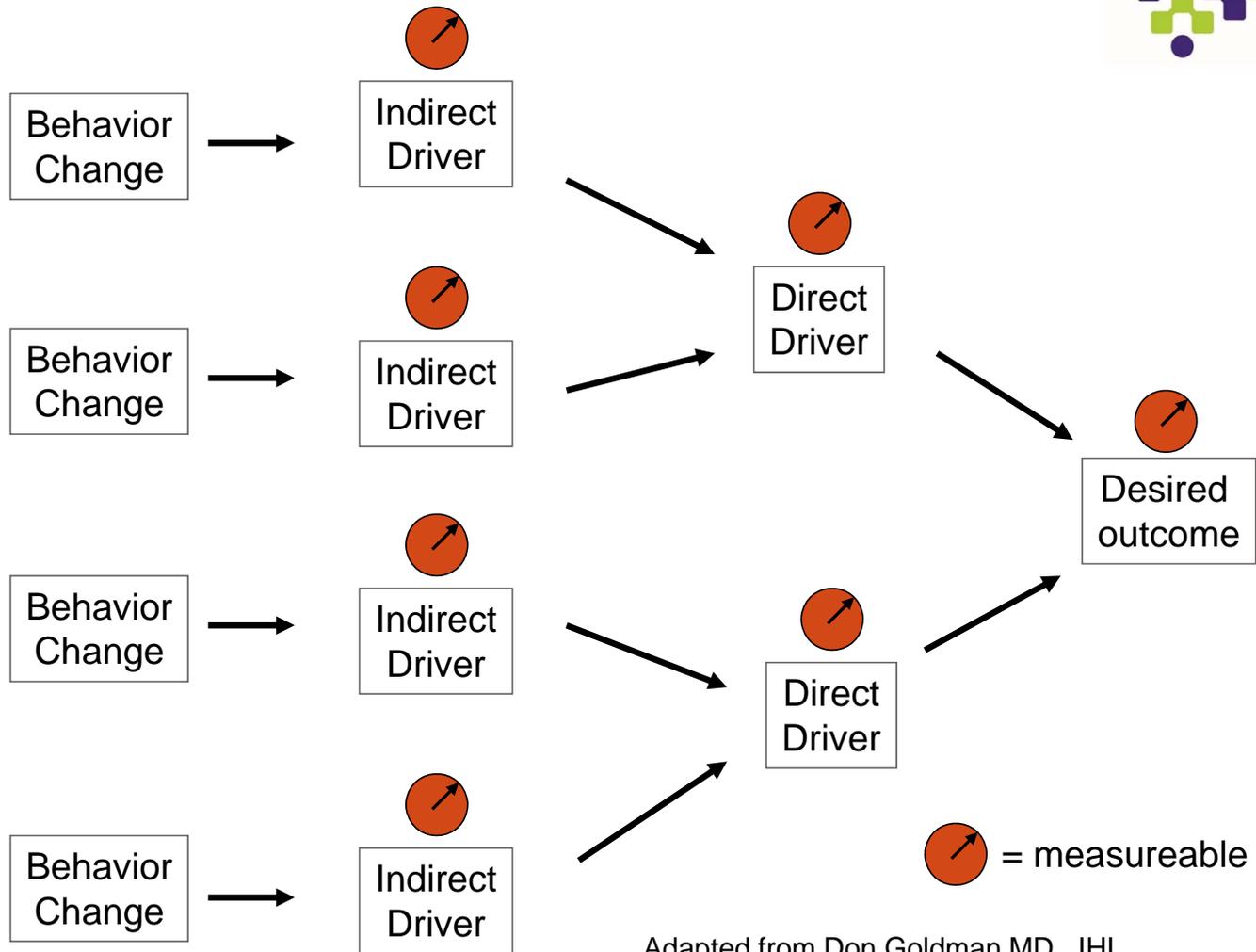


<http://www.youtube.com/watch?v=Ad9suSYL6RU>

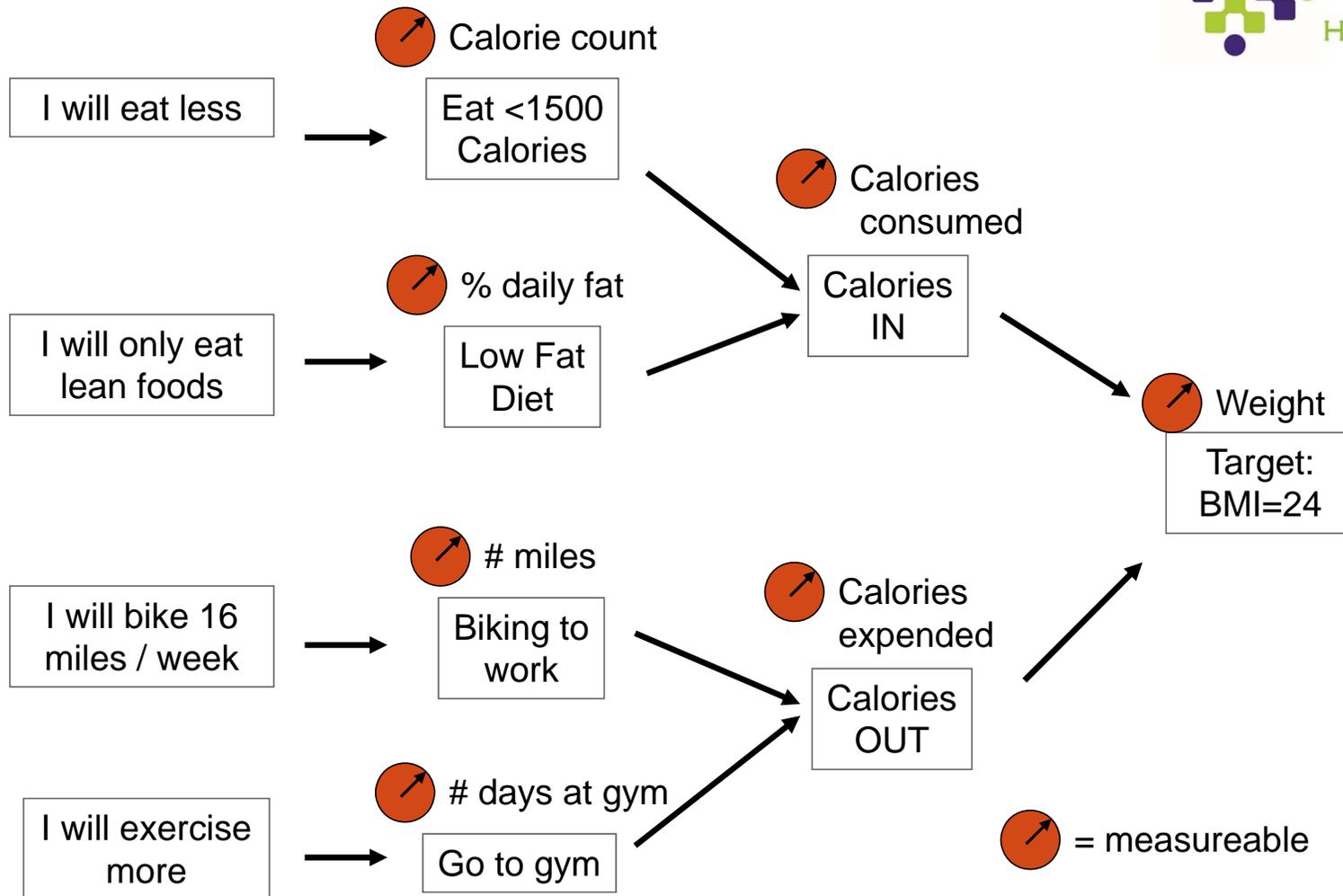
YOU WANT AN OUTCOME

- Visualize the improved future
- Describe what it looks like and its requirements
- What primary drivers will bring that into outcome into existence?
- What secondary drivers power the primary drivers?
- Measure the drivers and manage the measures

Driver Ed



Adapted from Don Goldman MD, IHI

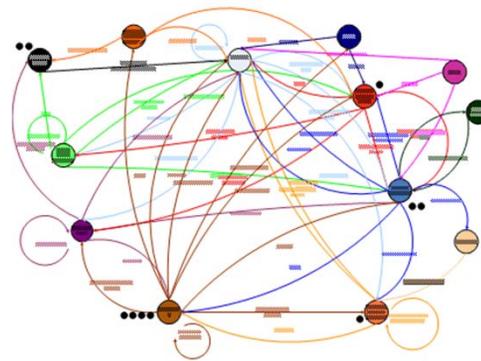


USE BUNDLES

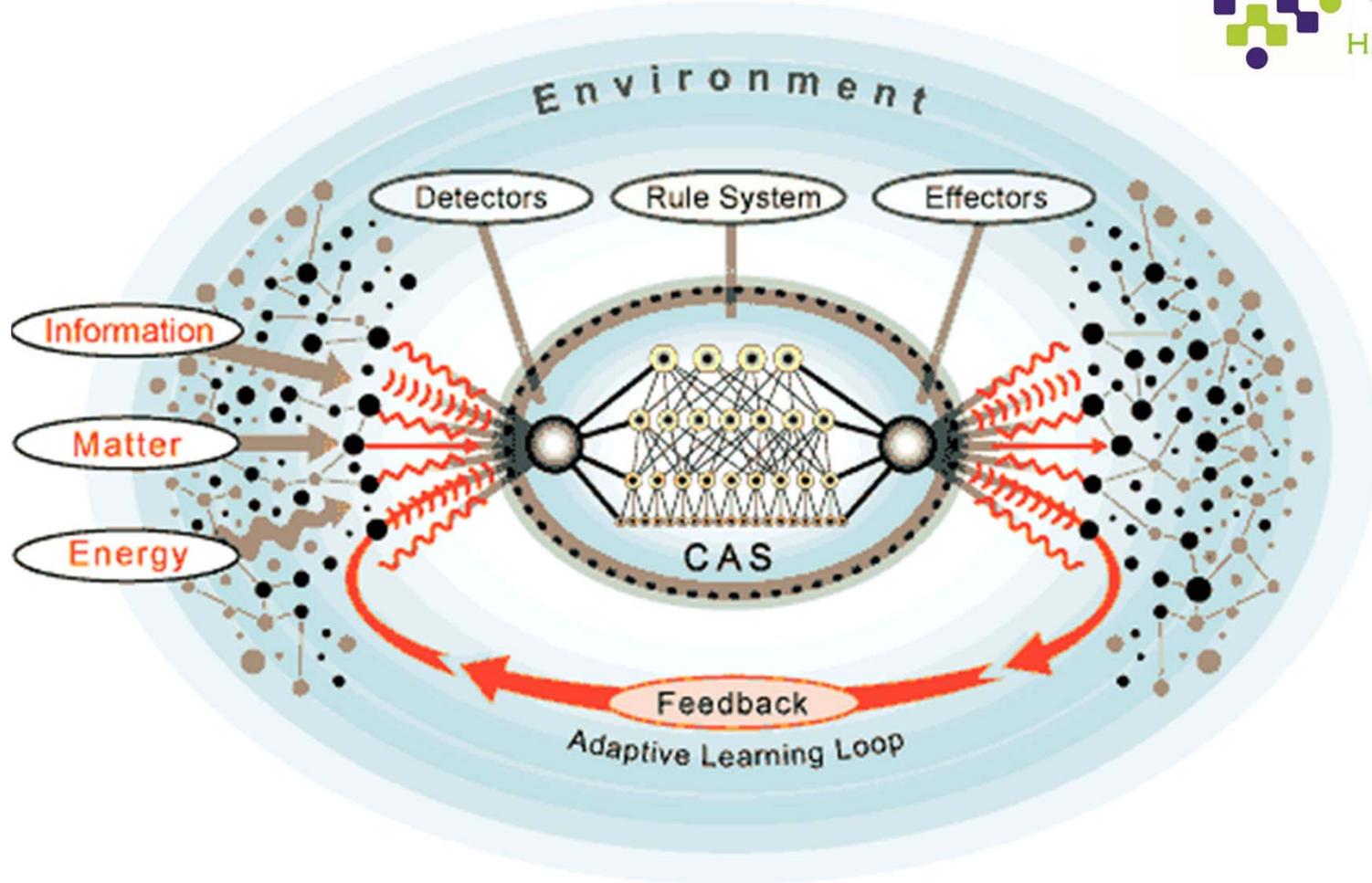
- Simpler than guidelines and policies
- Based on science – no discussion
- Scripted action sets with checklists
- Behaviorally anchored
- You either did it or you didn't
- The bundle is an “all or none” approach that works
- Easily observed as compliant or not

7. LEARN SYSTEMS THINKING

Sometimes influence is
more powerful than direct
action



Complex Adaptive System (CAS) Model

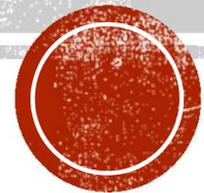


ANOTHER COMPLEX ADAPTIVE SYSTEM

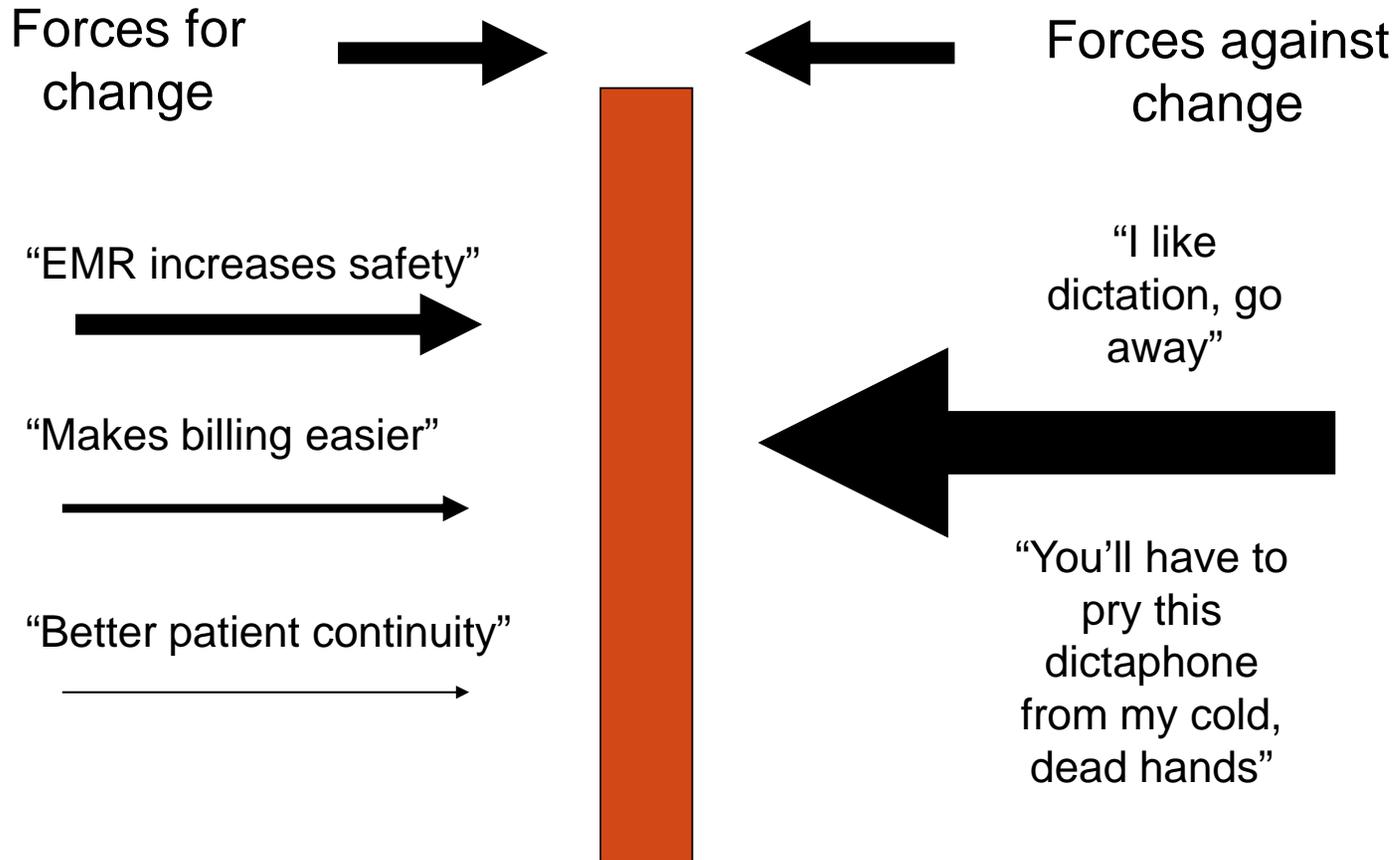


8. USE BEHAVIORAL CHANGE MODELS

Individuals and groups are more likely to change when there is a coordinated alignment of interests



“WE NEED TO START DIRECT ENTRY INTO THE EMR”

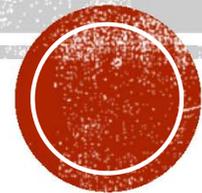


BEHAVIOR CHANGE REQUIRES

- Understanding of why the change is necessary
- A compelling reason to do it now
- Alignment of what the person needs with the goal
- Support for the new behavior
- Multiple reinforcers
- Short term wins
- Consistency with other life values
- Sustained reinforcement for new lifestyle

PUTTING IT ALL TOGETHER

What does it take to make a sustainable change in quality?



HAND SANITIZATION EXAMPLE



1. I must first *be aware* that there is a problem
 - Reflection, benchmarking, networking
2. I must *understand* the problem
 - What are the causal chain elements, antecedents and consequences
3. I must believe it is both *important* and a *priority*
 - Competing values must be defeated
4. I must appreciate the *consequences of failure*
 - Alignment of interests, appreciation of bad outcomes
5. I need to *remember to do it*
 - Behavioral cues to make it easy to focus
6. The materials needed must be *convenient*
 - Make it easy (convenience = compliance)

HAND SANITIZATION EXAMPLE (CONT)



7. I need to do it *effectively and consistently*
 - Mindfulness to technique, reliability in performance
8. I must be *reminded* (compelled) if I forget
 - Behavioral reinforcers and forcing functions
9. I must be *occasionally rewarded* for doing it
 - Intermittent reinforcement is the best teacher
10. It must be *measurable* and I must *see the measures*
 - What I am doing must make a difference in outcomes
11. I must *feel the accomplishment* of preventing harm
 - What I am doing must make a difference to patients

TABLE TASK

- Pick a persistent safety issue
- Detail the current state: the reasons the safety issue persists
- Use the methods we've discussed to plan an effective, persistent change
- Demonstrate why the change can happen
- Defend why it will persist in the new, changed culture
- Summarize the reasons why you think you will be successful

WAY FORWARD

- Make good on your personal commitment to patient safety
- Become your hospital's Safety Champion & create culture of safety at your hospital
- Set up incident reporting system at your hospital, and address safety issues

“A small group of thoughtful people could change the world. In fact, it’s the only thing that ever has.”

- Margaret Mead



QUESTIONS?

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