Patient Safety Overview

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Definitions

- **Patient Safety**
  - is a process that guards against any adverse condition occurring in a patient as a result of testing or treatment by caregiver(s).

- **Medical Error**
  - is the failure of a planned action to be completed as intended (i.e., error of execution) of the use of a wrong plan to achieve an aim.
Who is Responsible for Patient Safety?

- **All hospital employees**

- We strive to provide a blame free culture. Any employee who observes a patient safety risk should immediately report it to his/her direct supervisor.

- In addition, all employees have the right to report concerns about the safety or quality of care provided in the hospital to the Joint Commission.

- The hospital will take *no disciplinary action* because an employee reports safety or quality of care concerns to the Joint Commission.

- When an event occurs, appropriate interventions are dictated by the patient’s clinical conditions.

- Appropriate physician and hospital leadership are notified.

- Information and/or equipment related to the event are secured and preserved.

- Hospital encourages/supports staff that report actual or potential errors.
The Institute of Medicine (IOM) serves as adviser to the nation to improve health.

IOM Definition of Quality:
The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

(Institute of Medicine National Academies, www.iom.edu/CMS/8089.aspx)
In 1996, the Institute of Medicine (IOM) launched a concerted, ongoing effort focused on assessing and improving the nation's quality of care.

In 1999 the Institute of Medicine issued a report, citing 44,000 to 98,000 deaths in hospitals each year that can be attributed to medical errors.

The mistakes cost our country about $37.6 billion annually.

In an updated report, the Institute finds medication errors to be most common type of medical error, injuring at least 1.5 million people annually and costing an extra $3.5 billion for treatment.
To Err is Human: Building a Safer Health System (1999)

To Err is Human put the spotlight on how tens of thousands of Americans die each year from medical errors and effectively put the issue of patient safety and quality on the radar screen of public and private policymakers.
IOM Report

Crossing the Quality Chasm: A New Health System for the 21st century

The Quality Chasm report described broader quality issues and defines six aims—care should be safe, effective, patient-centered, timely, efficient and equitable
Sentinel Event

- An unexpected occurrence involving death or serious physical or psychological injury or the risk there of, a “near miss”
Examples of Sentinel Events

- Medication errors that result in harm to patients
- Wrong site Surgery
- Inpatient Suicide
- Infant Abduction
- Infant discharge to the wrong family
- Operative and post-operative complications
- Blood transfusion error
2014 National Patient Safety Goals
Goal 1: Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient’s room number)
  - Inpatients: Name and Medical Record Number
  - Outpatients: Name and Date of Birth

- Whenever administering blood or blood products; taking blood samples and other specimens for clinical testing, administering medications, or providing any other treatment or procedures
• Ask the patient (or surrogate) to state the patient’s name aloud.
  ◦ Do **not** state the patient's name before the patient (or surrogate) does
  ◦ Patients have been known to respond to names other than their own
• Compare the patient’s stated name with
  ◦ The name on his/her identification band

Goal # 1 cont – Patient Identification
• Compare the name and medical record number on the procedure, medication, specimen, transfusion forms, etc., to those on the patient’s identification band.
• Label specimens in the patient’s presence

• Verify that all identifiers on the specimen, related forms and the identification band correspond exactly

• Note – For blood transfusion, the hospital policy requires a signed and dated blood bank requisition and label on the specimen tube.

Goal # 1 cont – Patient Identification
Goal 2: Improve the effectiveness of communication among caregivers.

- For verbal or telephone orders or for telephonic reporting of critical test results
  - Write down the order or result
  - Verify the order or test result by having the person receiving the order or test result “read back” the complete order or test result
- Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values
- Implement a standardized approach to “hand off” communication, including an opportunity to ask and respond to questions – SBAR
- Do not use these abbreviations in any part of the Medical Record: Qd/qd, QOD/qod, U/u, IU/iu, Trailing Zero after decimal point (5.0 mg), Lack of leading Zero before decimal point (.5 mg), MS/ MSO4 or MgSO4 in stead of Morphine Sulfate or Magnesium Sulfate.
- Every Entry in the Medical Record must be signed, dated and timed.
Goal 3: Improve the safety of using medications.

- Identify and, at a minimum, annually review a list of look-alike/ sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.
- Label all medications, medication containers (e.g. syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.
- Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
Goal 3: Accurately and Completely Reconcile Medications Across the Continuum of Care

- There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the hospital.
- A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization (i.e., OR/Intensive Care Unit to General Floor, etc.)
- The complete list of medications is also provided and explained to the patient and family to communicate with the next provider (Primary care physician, Pharmacy, Nursing Home, etc.)
In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

The complete list of medications is also directly provided and explained to the patient and the family.

For ambulatory settings, each time patient visits, at the end of the visit their ambulatory medication list needs to be updated and a copy must be provided to the patient and or family member and for the next provider (pharmacist, physician, nursing home, etc).
Goal 6: Improve the safety of Clinical Alarm systems (phase 1)

- EP1
  As of July 1st 2014, leaders establish alarm system safety as a hospital priority
- EP2
  During 2014, identify the most important alarm signals to manage based on the following:
  - Input from the medical staff & clinical departments
  - Risk to patients if the alarm signal is not attended to or if it malfunctions
  - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
  - Potential for patient harm based on internal incident history
  - Published best practices and guidelines
Goal 6: Improve the safety of Clinical Alarm systems (phase 2)

EP3

As of January 1\textsuperscript{st}, 2016, establish policies and procedures for managing the alarms identified in EP2 & at a minimum, address the following:

- Clinically appropriate settings for alarm signals
- When alarm signals can be disabled
- When alarm parameters can be changed
- Who in the organization has the authority to set the alarm parameters
- Who in the organization has the authority to change alarm parameters
- Who in the organization has the authority to set alarm parameters to “off”
- Monitoring and responding to alarm signals
- Checking individual alarm signals for accurate settings, proper operation and detectability

EP4

As of January 1\textsuperscript{st}, 2016, educate staff and licensed independent practitioners about the purpose & proper orientation of alarm system as their responsibility.
Goal 7: Reduce the risk of Healthcare-Associated Infections

- Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Center for Disease Control and Prevention (CDC) hand hygiene guidelines
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.
- Prevent
  - Multidrug Resistant Organism
  - Central Catheter Associated Blood Stream Infections
  - Surgical Site Infections
  - Catheter Associated Urinary Tract Infection
Goal 15: The organization identifies safety risks inherent in its patient population. (suicidal ideation)

- The organization identifies patients at risk for suicide.
- Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
Conduct a pre-procedure verification process as described in the Universal Protocol (UP 1) – Correct person, Correct site and Correct procedure.

Mark the operative site as described in UP 1.

Conduct a “time-out” immediately before starting the procedure as described in the UP 1.
Time-out has the following characteristics: (1)

- It is standardized and defined by the hospital policy and NY State Law
- It is initiated by a designated member of the team (i.e., Registered Nurse)
- During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, OR technician, etc.
Time-out has the following characteristics: (2)

- When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
- During the time-out, the team members agree, at a minimum, on the following:
  a) Correct patient identity, b) The correct side and site, c) The correct procedure to be done.
- Document the completion of the time-out with the appropriate signature, Time and Date.
Failure To Rescue
The Institute for Healthcare Improvement has identified three main systemic issues that contribute to variability in hospital mortality rates:

- Failure in planning (includes assessments, treatments and goals)
- Failure to communicate (patients to staff, staff to staff, staff to physician)
- Failure to recognize deteriorating patient condition
AHRQ Patient Safety Indicators

- Complications of anesthesia
- Death in low mortality DRGs
- Decubitus ulcer
- Failure to rescue
- Foreign body left during procedure
- Iatrogenic pneumothorax
- Infections due to medical care
- Post-op hip fracture
- Post-op hemorrhage
- Post-op metabolic
- Post-op respiratory failure
- Post-op PE/DVT
- Post-op sepsis
- Post-op wound dehiscence
- Accidental puncture, laceration
- Transfusion reaction
- Birth trauma
- OB trauma - vaginal w/ instrument
- OB trauma - vaginal w/o instrument
- OB trauma - C-section
Core Measures

- Acute myocardial infarction (AMI)
- Heart failure (CHF)
- Pneumonia (PN)
- Pregnancy and related conditions (PR)
- Hospital-based inpatient psychiatric services (HBIPS)
  Children’s asthma care (CAC)
- Surgical care infection prevention (SCIP)
- Hospital outpatient measures (HOP)
- Venous thromboembolism (VTE)
- Stroke (STK)
Incident Occurrences

- For the purpose of hospital procedure, any incident/occurrence can be defined as any event that is not consistent with the desired operation of the hospital, or the care of patients.

- An incident maybe an event in which a patient is injured, or it may be an event in which there is a high potential for injury and/or property damage.
  - Document on a Patient Incident Report Form
Reporting Employee Accidents/Incidents

• Employee Accident and Investigation Report Form (E.A.R.)

• Employee incidents should be reported immediately to the supervisor of the employee involved
Techniques used to Perform a Root Cause Analysis

When a sentinel event occurs, a root cause analysis is performed to identify the problem.

Two techniques are used to perform the root cause analysis:

- Cause-and-effect diagram – to display the problem and underlying cause(s)
- Barrier analysis – to identify where “failures” to protect the patient occurs
Failure Mode & Effects Analysis (FMEA)

- Analytic techniques used to establish priorities
- Is a Proactive System Analysis
- Risk Priority Numbers are Analyzed
- Based on the opportunities for Improvements
- Completed in a multidisciplinary forum
To accomplish their goals, the Joint Commission uses a strategy called Tracer Methodology which
◦ examines how well the organization provides services
◦ focuses on how departments communicate and coordinate the care of patients, especially as patients transfer from one unit to another

Priority Focus Areas include the following
◦ Assessment and Care/Services
◦ Communication
◦ Physical Environment
◦ Patient Safety
◦ Orientation and Training
Priority Focus Areas

• **Assessment and Care/Services**
  ◦ Assessment
  ◦ Reassessment
  ◦ Planning of care, treatment, and/or services
  ◦ Provision of care
  ◦ Discharge planning or discontinuation of services

• **Communication**
  ◦ Provider and/or staff-patient communication
  ◦ Patient and family communication
  ◦ Staff communication and collaboration
  ◦ Information dissemination
  ◦ Multidisciplinary teamwork
  ◦ Medication Reconciliation
  ◦ Handoff Communication
    • SBAR
      ◦ Situation
      ◦ Background
      ◦ Assessment
      ◦ Recommendation
Priority Focus Areas

- **Physical Environment**
  - Physical design
  - Construction and redesign
  - Maintenance and testing
  - Planning and improvement
  - Risk prevention

- **Orientation and Training**
  - Assessing competencies
  - Orientation
  - Continuing education
  - Training for licensed independent practitioners

- **Patient Safety**
  - Planning and design of services
  - Directing Services
  - Integrating and coordinating services
  - Reducing and preventing errors
  - Using sentinel event alerts
  - Meeting the National Patient Safety Goals
  - Using clinical practice guidelines
  - Activities involving patients in their care
"Problems cannot be solved by the same level of thinking that created them." — Albert Einstein

The opportunity for Change is HERE

Let’s stay focused on Establishing And Sustaining a Healthy Work Environment
“We are what we repeatedly do. Excellence, therefore, is not an act, but a habit.”
Patient Safety

Quality
Do the right thing at the right time

Efficiency
Do it without wasting resources

Excellence
High Reliability
Thank you for your attention!!!!!!