

PHYSICIAN PATIENT SAFETY TRAINING

WHAT IS PATIENT SAFETY?

Patient safety is defined by the National Patient Safety Foundation as the prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors. Errors can be classified as errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly).

Although providing safe care has been recognized as a duty for centuries, the emphasis has changed from the **person model**, which assumes that mistakes are made through carelessness or lack of knowledge, to the **systems model**, which recognizes that anyone can make a mistake and that systems need to be put into place to prevent mistakes from reaching the patient.

Patient Safety emphasizes:

- Reporting of errors without fear of retribution
- Proactive reporting and systems analysis of close calls and hazards
- Importance of teamwork
- Improving existing processes
- Proper design of new processes
- Individual accountability
- Involvement of the patient and family

WHY IS PATIENT SAFETY GETTING SO MUCH ATTENTION NOW?

In their 1999 report, *To Err is Human*, the Institute of Medicine (IOM) emphasized that most medical errors are systems-related and not usually attributable to individual negligence or misconduct. Since then, patient safety has been a major focus of governmental agencies, consumer groups, and professional organizations. For example, the Joint Commission on Accreditation of Health care Organizations (JCAHO) has established patient safety standards for hospitals. Groups like Leapfrog (a group of large business leaders who are using their purchasing power to influence quality of care) set standards that healthcare institutions strive to meet for both patient safety and business reasons. Extensive media coverage on high-profile errors has influenced the public. Consumer groups encourage patients to "Speak Up" in order to keep themselves safe in hospitals. Still today over 20,000 deaths occur annually as a result of medication errors alone. Medical errors are the 6th largest cause of death in the US.

WHAT FACTORS AFFECT PATIENT SAFETY?

- Human** (judgment, training, communication, stress, fatigue)
- Environmental** (distractions, interruptions, noise, clutter, lighting)
- Patient** (behavior, compliance, health literacy, fear, disease acuity)
- Technology** (design, packaging and labeling, variability)
- System** (policies and procedures, supervision, complexity, handoffs, workflow)
- Leadership** (lack of visibility, blame and shame, inadequate resources)

According to a recent survey of physicians, some of the barriers to improving patient safety are:

Tolerance and complacency: the notion that mistakes are bound to be made and that nothing can be done about it. Between 50-80% health care workers who witness clinicians cut corners, make mistakes or demonstrate dangerous incompetence and remain silent. (AACN, Vital Smarts)

Denial: the failure to report or admit a mistake for a variety of reasons, including fear of being sued. Recent reforms at U-Michigan Health System have demonstrated with full transparency and disclosure the numbers of suit cases and costs have both dropped by 2/3rds over a five year period. (Richard Boothman Chief Risk Officer UMHS)

Professional authority: our system of health care makes it unlikely that nurses, residents and other healthcare staff or patients will speak up about a problem. And even if they do, physicians will not always listen to them. If a witnessed medical error involves a physician, only 1 in 20 health care workers will speak up. (AACN, Vital Smarts)

WHAT IS THE 'SYSTEM APPROACH' TO PATIENT SAFETY

Studies of factors that contribute to error in patient care show that the majority of errors are caused by faults intrinsic to the process by which healthcare is delivered, therefore, errors are reduced most effectively by looking at the whole system to analyze why they occur, and how the underlying root causes can be eliminated.

Objectives of a systems approach include: streamlining the delivery process, building safeguards that reduce the likelihood of errors and providing an early warning system when errors do occur so that they can be addressed before they negatively impact the patients' welfare.

WHAT ARE SOME OF THE THINGS THE HOSPITALS HAVE DONE?

Each hospital has a patient safety committee with multi-disciplinary representation and a patient safety policy, which emphasizes prevention (using automation, computerization, education and process design), detection (reporting of occurrences, close calls and hazards) and correction (using the quality improvement process to improve safety).

The Hospitals also have Medication Safety Committees chaired by physicians. The Committees meet monthly to discuss the root causes of specific occurrences, trends of actual and prevented occurrences, issues related to POM and general information on how to improve medication safety.

The Emergency Departments have done teamwork training to formalize communications, such as repeating back information, and to develop teamwork skills.

Implementing POM, as well as linkages between department computer systems, has reduced reliance on memory and reduced errors related to handwriting and incomplete orders.

WHAT CAN THE PHYSICIAN DO TO IMPROVE SAFETY?

1. Be aware of and support the JCAHO patient safety goals:

A. Improve the accuracy of patient identification

- Use the patient's full name and DOB whenever administering medications or blood products; taking blood samples and other specimens for clinical testing or providing any other treatments or procedures.
- Follow the requirements for the Universal Protocol & Time-Out.

B. Improve the effectiveness of communication among care givers

- 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 information “read-back” the complete order or test result.
- Avoid using the prohibited abbreviations listed below.
- improve the timeliness of responding to critical test results and values. (Critical test results are defined as stat results, panic values and unexpected findings with an immediate impact on clinical care that requires immediate clinical action (<1hr.)
- Use the Signout feature on the Lifespan Intranet to standardize hand-offs. Utilize iSBAR methods to communicate changes in patient conditions among and between health care workers.

***DO NOT USE UNACCEPTABLE ABBREVIATIONS - SEE TABLE BELOW**

Unacceptable	Description	Acceptable
Dig.	Digitalis/digoxin	Write "digoxin"
DTO	Deodorized/Diluted Tincture of Opium	Write “Deodorized Tincture of Opium” or “Pediatric Morphine Oral Solution 0.4 mg/mL”
gr.	Grain	Use the metric system
IU	International unit	Write "international unit"
Lack of Leading Zero (.Xmg)		Ex: <u>0.3 mg acceptable</u> .3 mg unacceptable
Trailing Zero (X.O mg)		Ex: <u>3 mg acceptable</u> 3.0 mg unacceptable
MS & MSO4	Morphine Sulfate	Write "Morphine"
MgS04	Magnesium Sulfate	Write "Magnesium Sulfate"
Nitro.	Nitroglycerin	Write "Nitroglycerin" or "Nitroprusside"
Qd or QD/qod or QOD/QID	Daily/every other day/4 times day	Write "daily" or "every other day" or "four times daily"
U	unit	Write "units"

C. Improve the safety of using medications

- 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.
- Utilize anticoagulation protocols available in POM.

D. Reduce the risk of health care-associated infections

- Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines. Foam in –Foam out, adhere to isolation precautions by appropriately donning PPE.

Participate in Root Cause Analyses for identified cases of unanticipated death or major permanent loss of function associated with health care-associated infection.

E. 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 with the involvement of the patient. Include a comparison of the medications you are prescribing to those on the list.
- Reconcile the list of home medications to the active medication regime when accepting patients in transfer.
- Reconcile the list of home medications to the discharge medication list, Communicate the reconciled list of discharge medications to the next provider of service, within or outside the organization.

F. Reduce the risk of patient harm resulting from falls

.Participate in the fall prevention program: after examining the patient return side rails to the upright position, keep call bell and bedside table in patient's reach.

G. Identify patients at risk for suicide

H. Respond rapidly to changes in patient's condition

- Empower staff, patients and/or families to request additional assistance when they have a concern about the patient's condition
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2. Practice and model good communication skills

- Encourage participation by all members of the patient care team, such as a quick explanation prior to surgery of what you plan to do, what the crucial points are and what equipment you will need. Ask them to speak up if they see a potential problem.
- Provide sufficient information to all members of the care team and expect the same in return.
- Involve patients and families by listening to them and providing information in a manner they can understand

3. Report incidents and near misses

- Can now be reported on the Lifespan Intranet

- Go to Employee Tools
- Go to Occurrence Reporting (upper right hand corner of the page)
- Click on the appropriate hospital
- Choose the type of report

4. Avoid reliance on memory

- Use protocols, checklists, POM
- Develop a results tracking system for your office practice

5. Participate in Hospital programs

- Attend M&M conferences
- Contact the Hospital Safety Committee through the Quality Management Department to report system problems and to make suggestions for system improvements