

# The Quality Colloquium at Harvard University

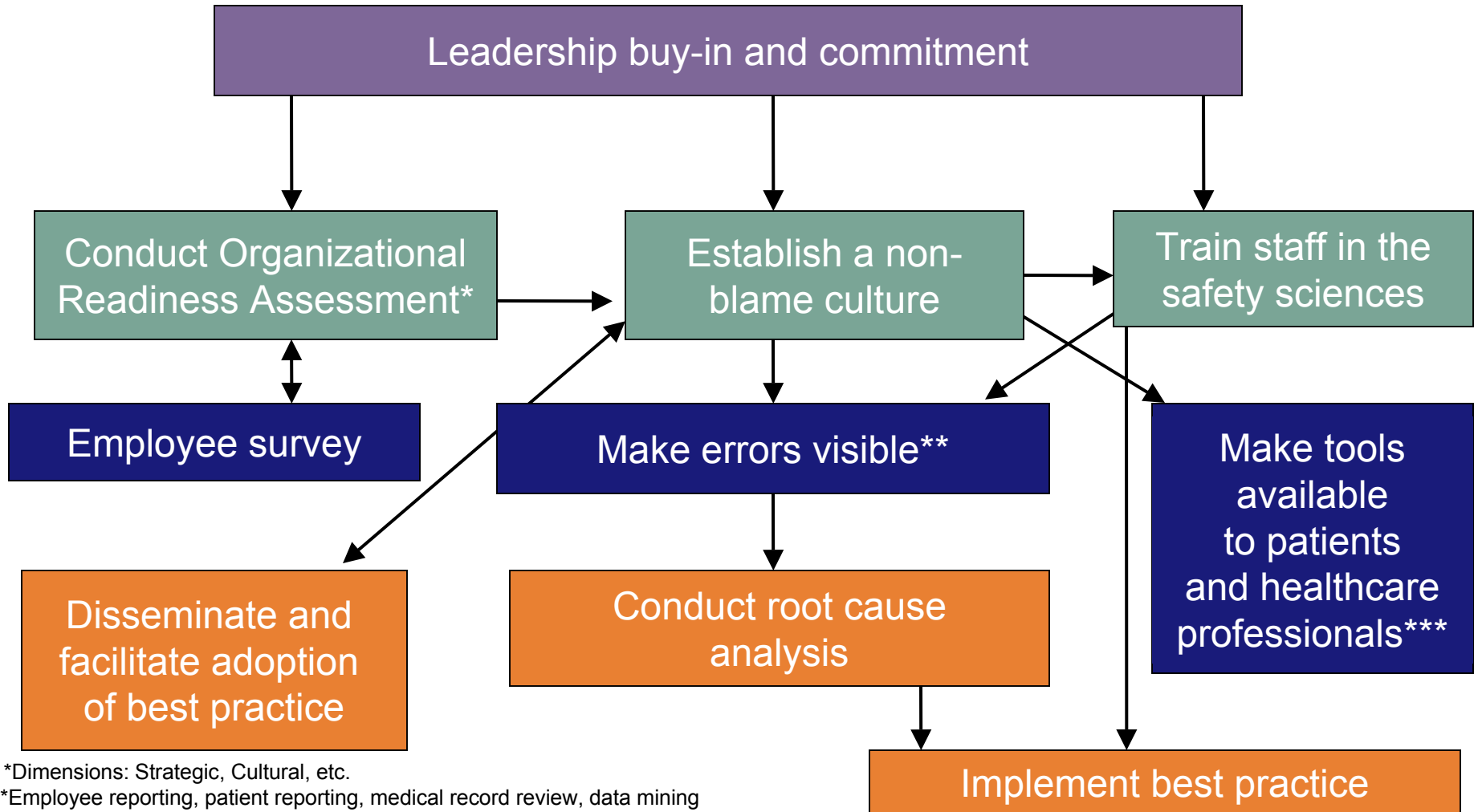
## August 27, 2003

### Patient Safety Organizational Readiness Assessment Tool

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# An Agenda to Improve Patient Safety

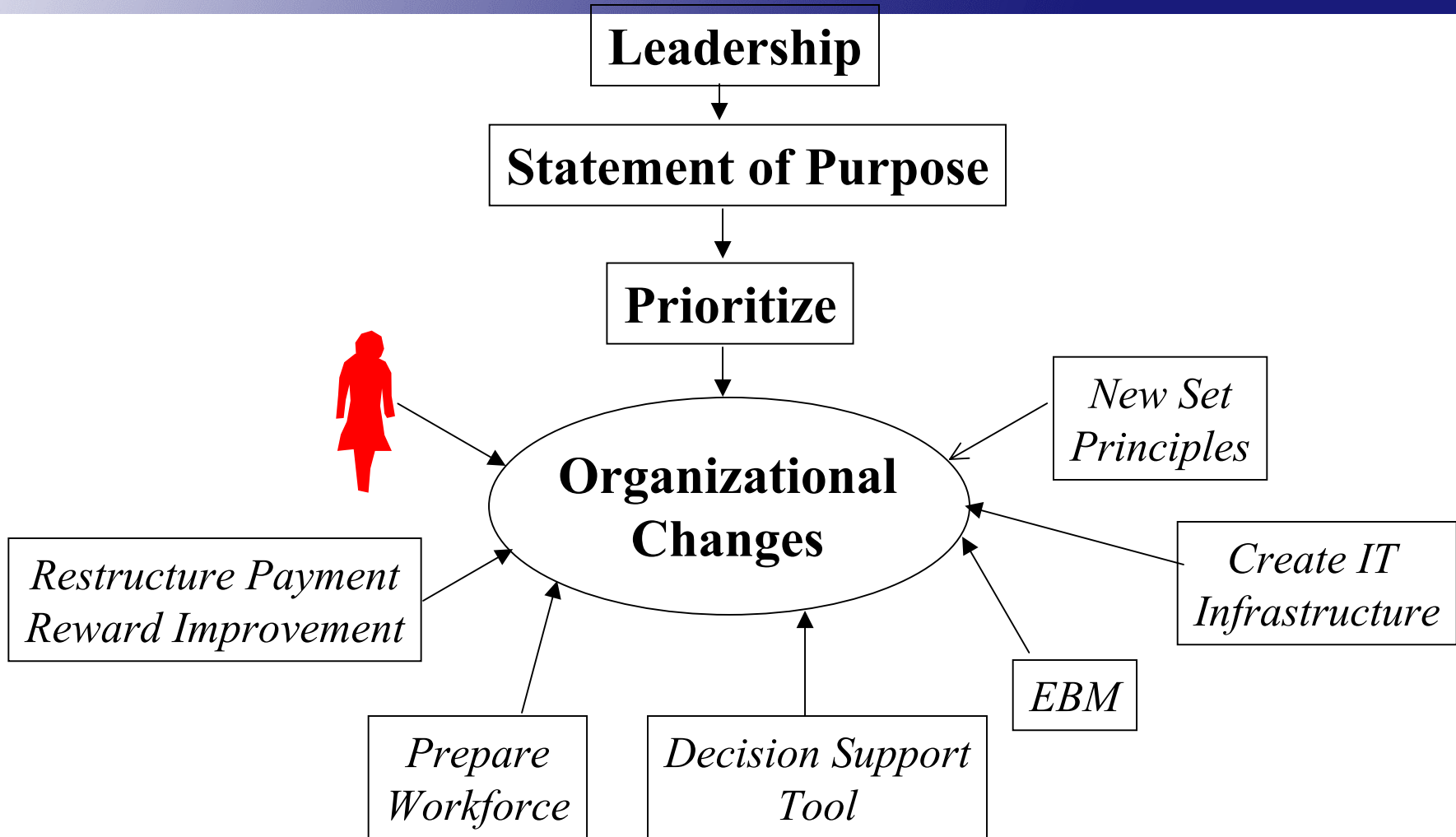


\*Dimensions: Strategic, Cultural, etc.

\*\*Employee reporting, patient reporting, medical record review, data mining

\*\*\*Point of care and near term

# Crossing the Quality Chasm



Ref: Adapted from IOM Report: March 01.

Harvard Quality Colloquium 8-27-03

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# Discussion Outline

- Overview of the Patient Safety Organizational Assessment Tool (PSOAT)
- Conceptual Framework
- Project Steps
- Results of Delmarva Assessment

# Objectives of the Assessment

- Use an evidence-based process to:
  - Provide gap analysis
  - Highlight practices that contribute to errors
  - Jump start safety programs
  - Comply with regulatory requirements

# Patient Safety Organizational Assessment Tool Description

- Content
  - 100+ focused practices from the literature organized by:
    - Strategic
    - Structural
    - Cultural
    - Technical
    - Medication Administration
    - Patient Involvement

# Literature Sources

- National Patient Safety Foundation, Institute of Medicine
- Agency for Healthcare Research and Quality
- Literature Citation Systems
  - PubMed, MEDLINE, MDConsult
- MEDSTAT internal resources
  - Clinical reference database (6000+ references)
- Medical and Patient Safety web sites and listservs
- Web engines

# Description of Shortell Framework

<b>Category</b>	<b>Description</b>	<b>Examples</b>
Strategic	Organization articulates what is important; organization provides resources and focus	<ul style="list-style-type: none"><li>• Mission statement</li><li>• Organizational safety plan</li><li>• Executive leadership</li><li>• Board involvement</li></ul>
Cultural	Underlying beliefs, values, norms and behaviors	<ul style="list-style-type: none"><li>• Open non-punitive milieu</li><li>• Teamwork</li><li>• Learning from mistakes</li></ul>
Technical	Informational services and education	<ul style="list-style-type: none"><li>• Safety training programs</li><li>• Information systems related to safety</li><li>• Standards</li></ul>
Structural	Operational structures for organizational learning	<ul style="list-style-type: none"><li>• Best practices sharing</li><li>• Electronic communication for shared learning</li><li>• Committee structures</li></ul>

Shortell S. Assessing the impact of Continuous Quality Improvement on Clinical Practice: What it will take to accelerate progress. The Milbank Quarterly, 76(4) 1998

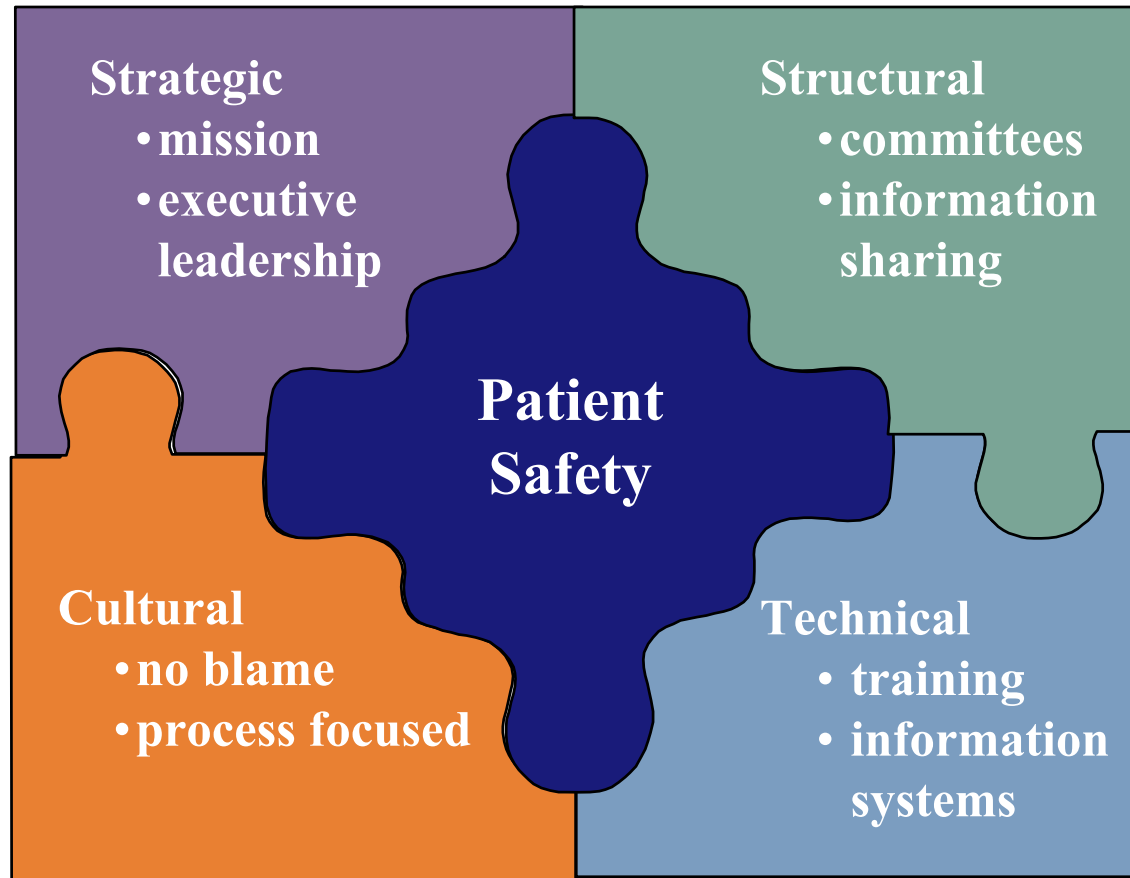
# Impact on Quality Improvement

<i>Strategic</i>	<i>Cultural</i>	<i>Technical</i>	<i>Structural</i>	<i>Results</i>
	<b>X</b>	<b>X</b>	<b>X</b>	<ul style="list-style-type: none"> <li>No significant results on anything really important</li> </ul>
<b>X</b>		<b>X</b>	<b>X</b>	<ul style="list-style-type: none"> <li>Small, temporary effects; no lasting impact</li> </ul>
<b>X</b>	<b>X</b>		<b>X</b>	<ul style="list-style-type: none"> <li>Frustration and false starts</li> </ul>
<b>X</b>	<b>X</b>	<b>X</b>		<ul style="list-style-type: none"> <li>Inability to capture the learning and spread it throughout the organization</li> </ul>
<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<ul style="list-style-type: none"> <li>Lasting, organization-wide impact</li> </ul>

**X** = fully present

Shortell S. Assessing the impact of Continuous Quality Improvement on Clinical Practice: What it will take to accelerate progress. The Milbank Quarterly, 76(4) 1998

# Impact on Safety Improvement



Ref: Shortell: Milbank Quarterly, 76(4)1998

# Value to Participating

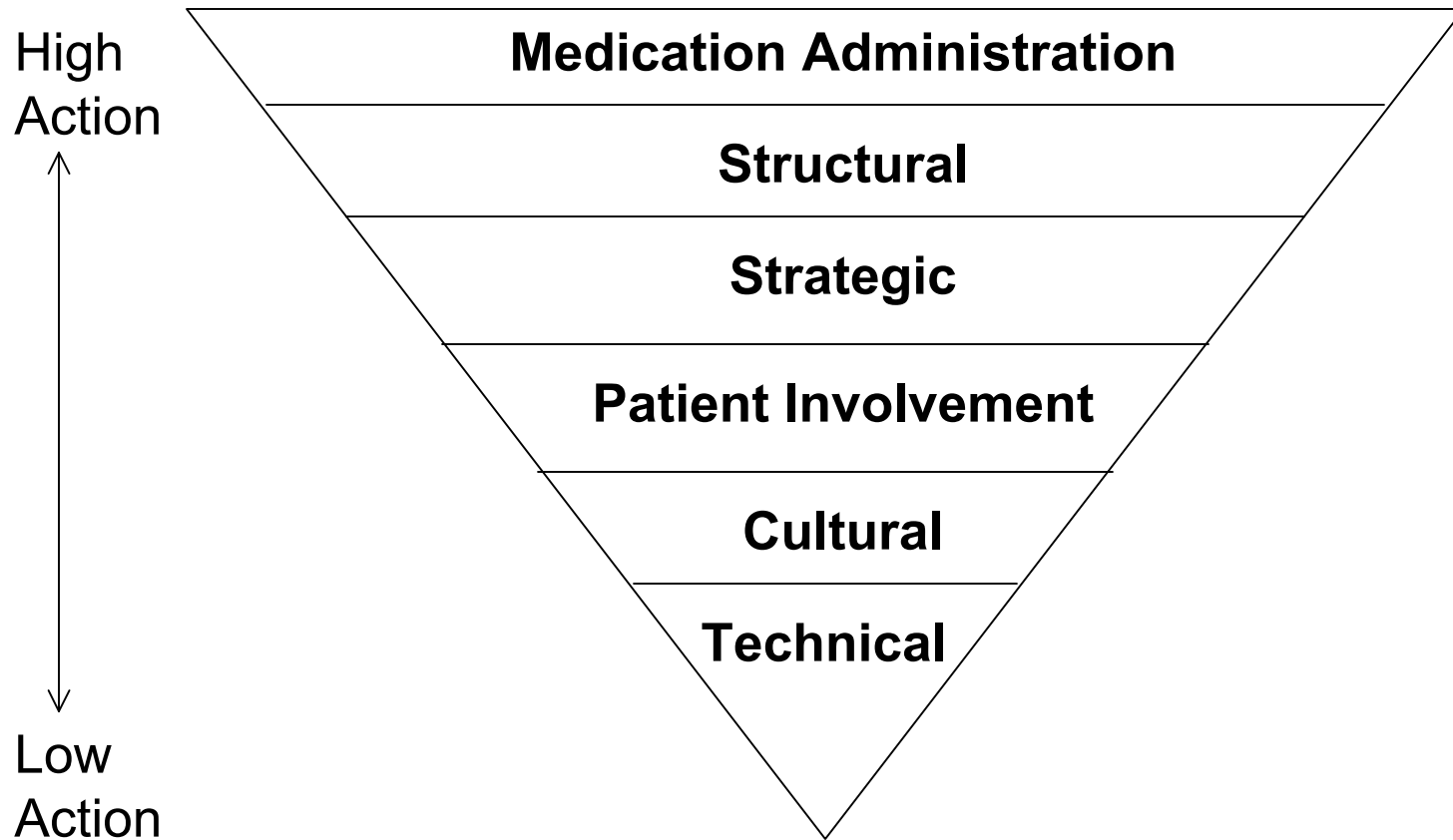
- Avoid costs
- Focus resources/attention
- Market to community
- Increase collaboration

# Project Steps

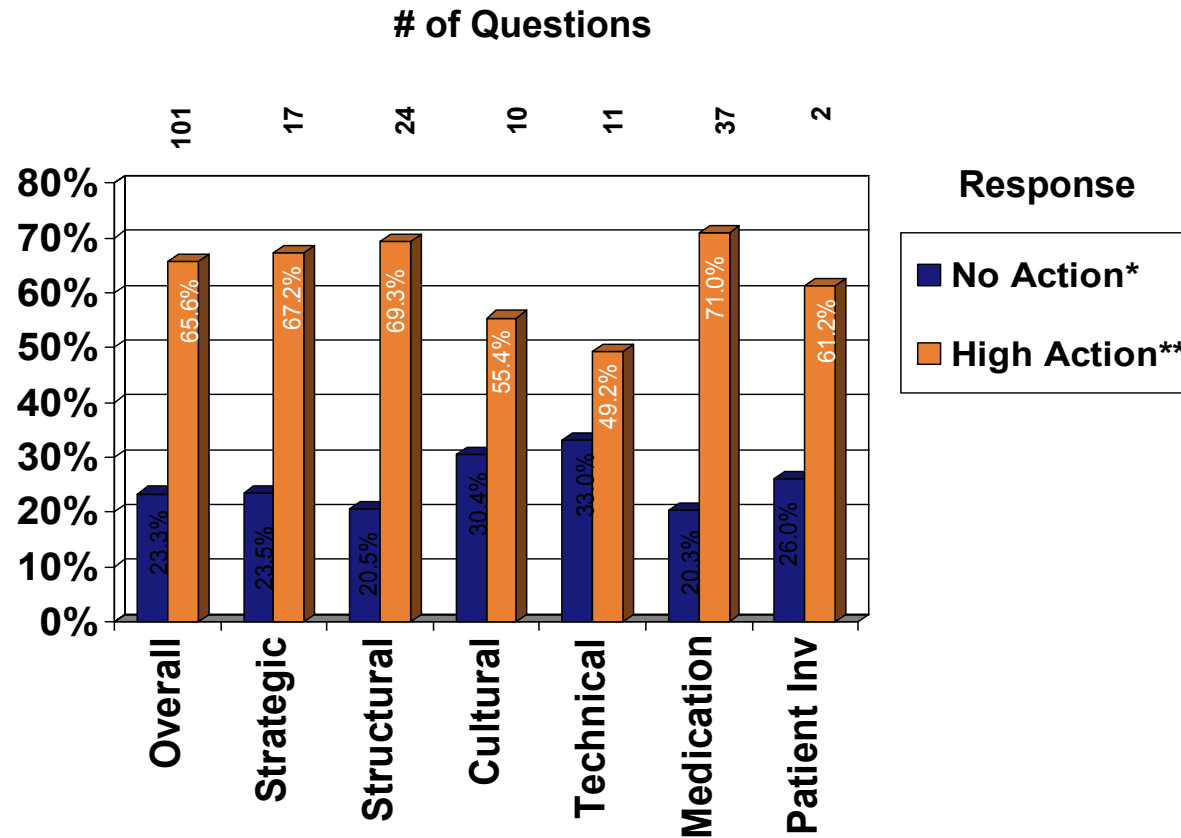
- Delmarva and MEDSTAT partner to customize and offer tool to MD and DC health care organizations
- Invitation to participants
- 42 organizations assigned IDs; 24 completed
- Bedsize - 8 had <150 beds; 16 had  $\geq$ 150 beds
- Results aggregated and analyzed
- Obtain participant feedback

# Findings

# Overview of Results: Level of Action



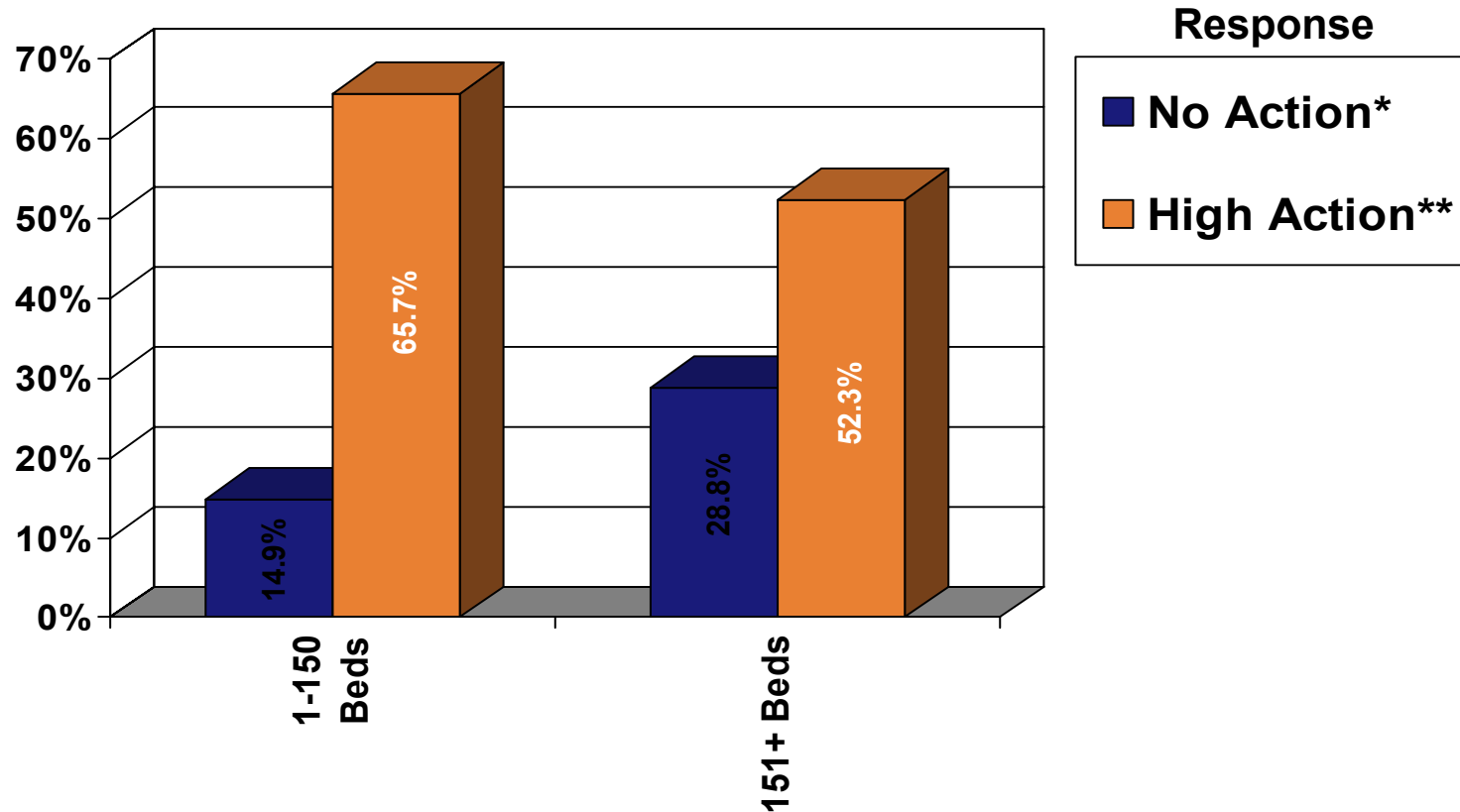
# Percentage Response by Section



\*No Action – Answered 1 or 2 on assessment tool. 1 = Not considering the practice; 2 = Discussed the practice, but no action taken to put into place.

\*\*High Action – Answered 4 or 5 on assessment tool. 4 = Considerable action taken to put practice into place; 5 = The practice is fully implemented in organization.

# Difference by Bed Size: Patient Involvement



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# Strategic - Low vs. High Action: 17 Questions

## ***Not considering or no action taken (>60% of Responses)***

- Mission statement includes patient safety
- Employee patient safety handbook

## ***Practice fully implemented or considerable action taken (>90% of Responses)***

- Written patient safety plan-board reviewed
- Section on safety improvement in annual review
- Established safety program; focus on culture

# Structural - Low vs. High Action: 24 Questions

## ***Not considering or no action taken (>60% of Responses)***

- Patient safety discussed at staff meetings
- HR policy for avoiding potential safety errors due to fatigue, stress

## ***Practice fully implemented or considerable action taken (>90% of Responses)***

- Safety reports reviewed by multidisciplinary teams
- CMS compliant restraint policy
- Fall protocol in place
- Infection control program in place with monitors/trends
- Risk management and patient safety program integrated
- Life safety integrated in patient safety

# Cultural - Low vs. High Action: 10 Questions

## ***Not considering or no action taken (>60% of Responses)***

- Financial reward for suggested improvement
- Annual survey of perceptions on culture
- No 'incident reports' – rename

## ***Practice fully implemented or considerable action taken (>90% of Responses)***

- Encourage near miss reporting for improvement
- Simple, confidential, standardized reporting forms
- No incident reports in personnel files
- Use root cause analysis for improvement

# Technical - Low vs. High Action: 11 Questions

## ***Not considering or no action taken (>60% of Responses)***

- Videotape procedures (e.g. surgery) for improvement
- Bar code blood transfusions
- IT for order entry

## ***Practice fully implemented or considerable action taken (>90% of Responses)***

- Voluntary, open, confidential, non-punitive, objective error reporting system in place

# Medication Safety - Low vs. High Action: 37 Questions

## ***Not considering or no action taken (>60% of Responses)***

- Electronic xmit of orders; Information system available to all clinical staff
- Bar coding at point of administration
- Lab/vital sign monitoring in place for hazardous drugs
- Lab and medical records at bedside

## ***Practice fully implemented or considerable action taken (>90% of Responses)***

- Ongoing education of drug administration
- Allergy info visible on patient orders
- All drug orders reviewed by pharmacist before dispensing
- No rarely used narcotics in patient care areas
- Morphine – limited doses, well marked

# Medication Safety - Low vs. High Action: 37 Questions

***Not considering or no action taken  
(>60% of Responses)***

***Practice fully implemented or considerable action taken  
(>90% of Responses)***

- No stocking or unique storage of look-alike drugs
- Pharmacy or manufacturer responsible for admixing or preparing unit doses
- Antidotes for high risk drugs widely available
- Standardized stocking of drugs on unit
- Standardized drug admin times

# Medication Safety - Low vs. High Action: 37 Questions

***Not considering or no action taken  
(>60% of Responses)***

***Practice fully implemented or considerable action taken  
(>90% of Responses)***

- Drug information widely available for new or unusual drugs
- IV compatibility charts on care unit
- Alphabetic list of drugs by brand name/generic on care unit
- 24/7 Pharmacist staffing

# Recommendations Based Upon Survey Results

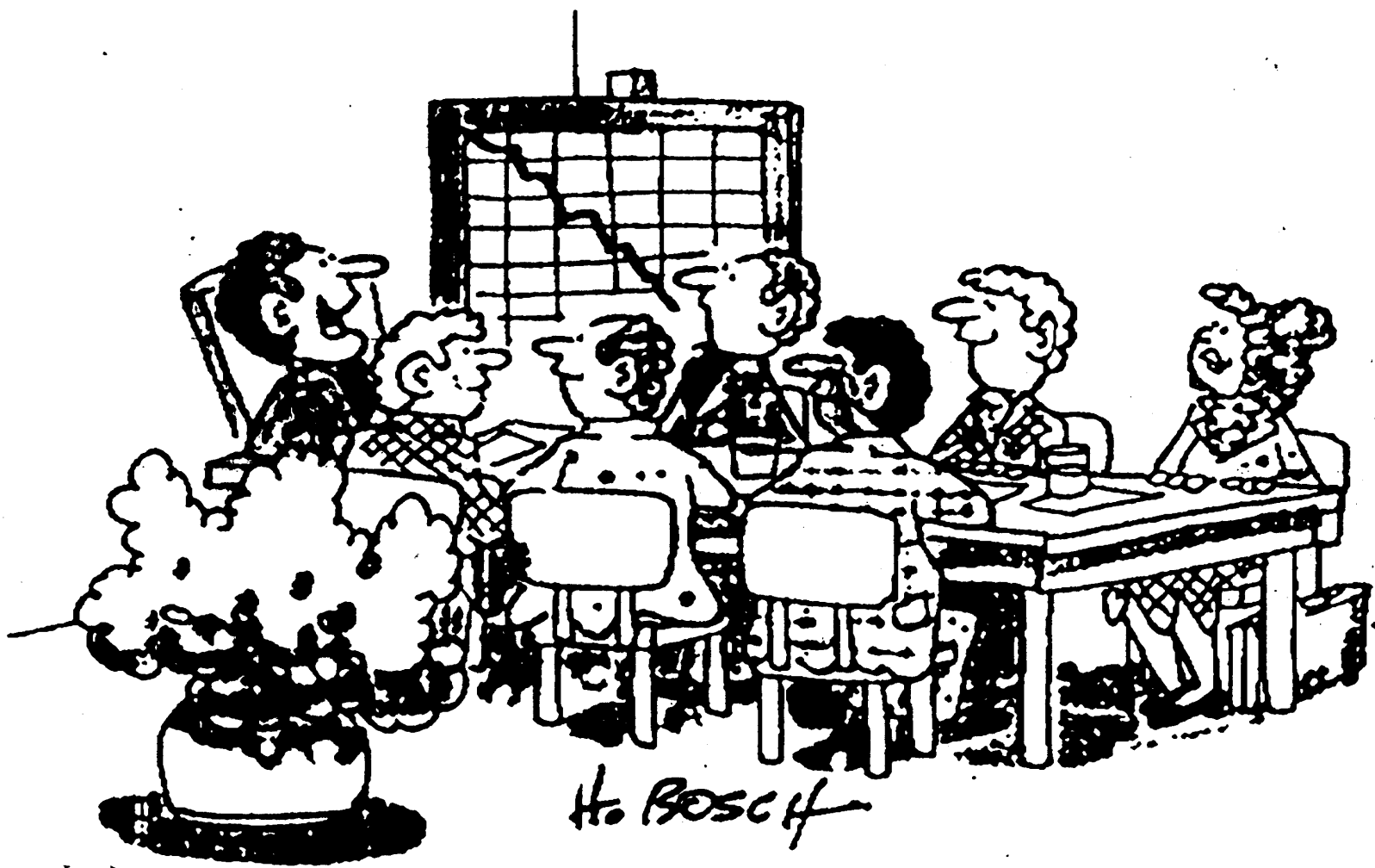
# Strategic/Structural

- Incorporate patient safety into mission statement
- Improve policy and departmental standards to incorporate safety discussion into operational meetings



# Cultural

- Raise awareness at all levels of organization
- Reward staff for improvements; consider alternative reward systems
- Celebrate achievements
- Gather baseline staff perceptions for both information and awareness



*"All those in favor of blaming this on Watson,  
here please signify by saying 'aye!'"*

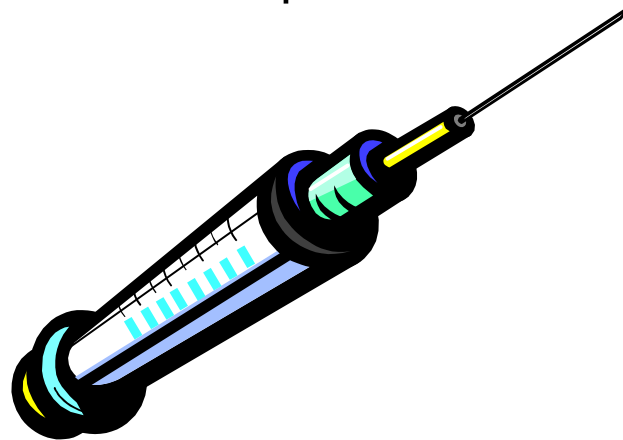
# Technical

- Bar coding for patient identification, patient tracking, CPOE
- Explore other techniques for potential error review e.g. user centered design
- Electronic decision support for clinicians



# Medication Safety

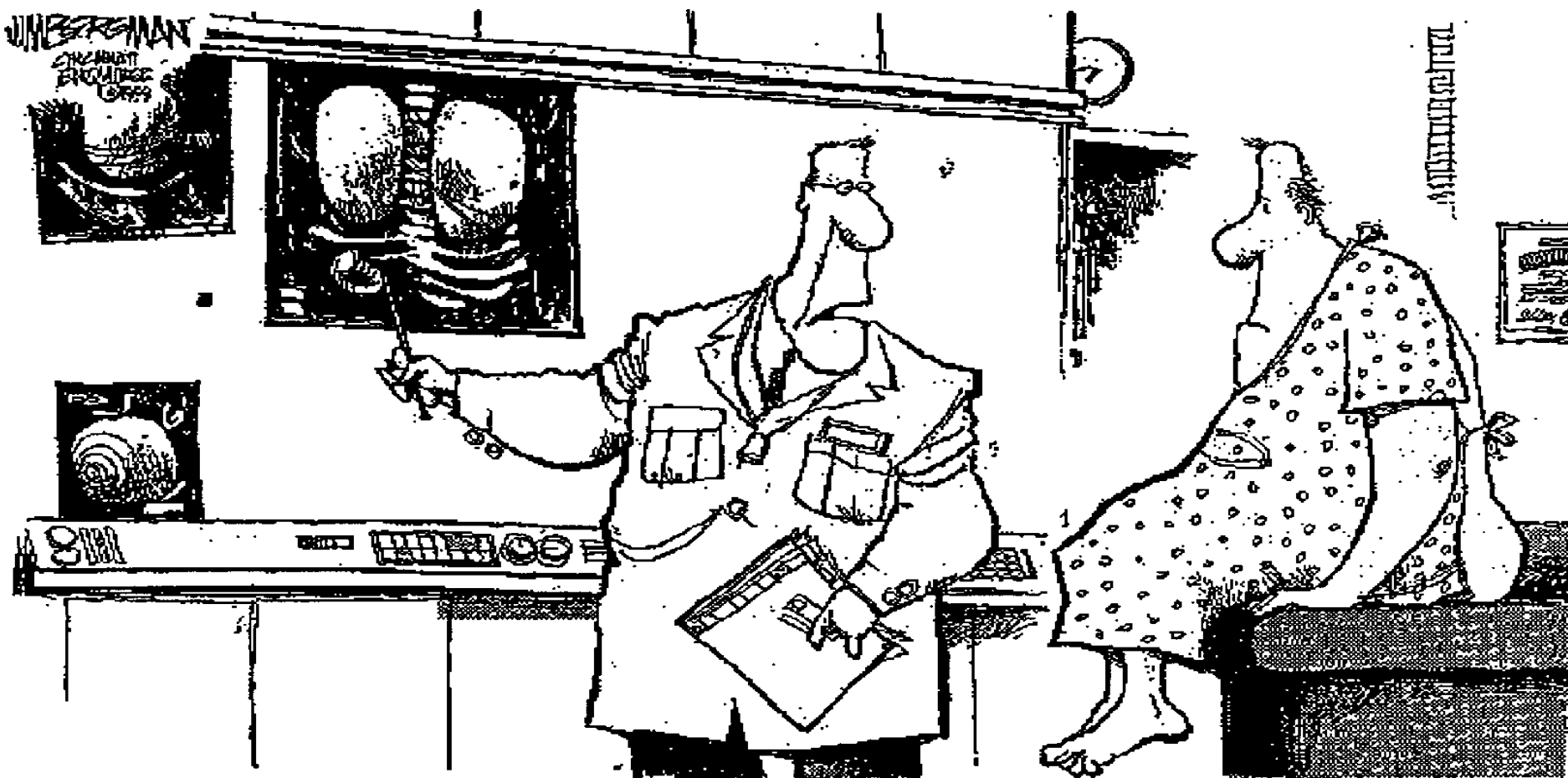
- Standard policies in place to monitor patients on hazardous drugs
- Availability of medication information system to all clinical staff dealing with a patient
- Bar-coding to detect adverse drug reaction and other administration errors at point of care



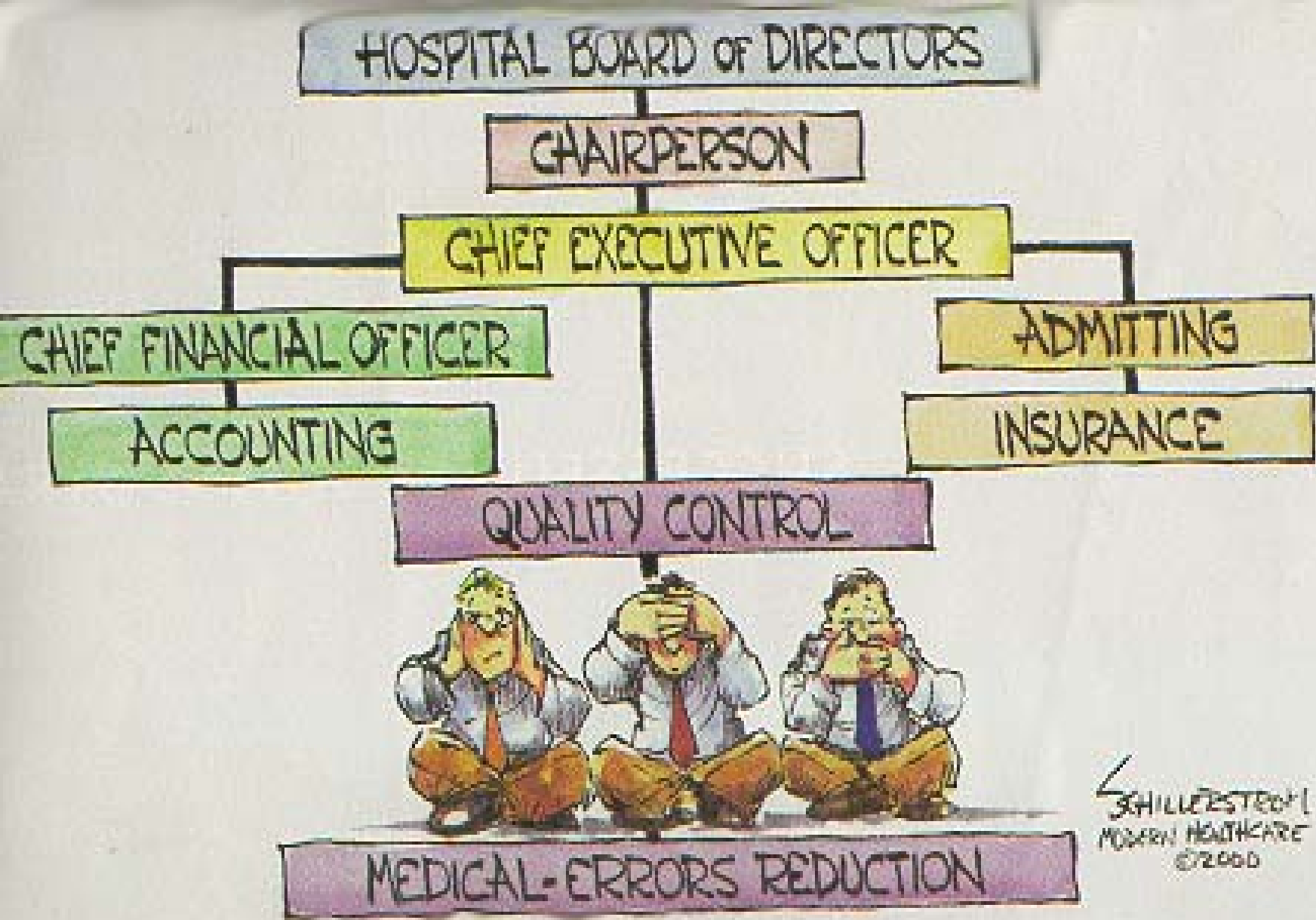
# Patient Involvement

- Educate patients and families on key safety issues regarding their care while hospitalized
- Educate patients and families about medication safety after discharge
- Develop safety educational programs geared towards patients
- Be mindful of following hand washing procedures





**"CONTRARY TO ALL THESE REPORTS ON DOCTOR ERRORS, MR. JOHNSON, YOUR SURGERY WAS PERFORMED COMPETENTLY AND PUNCTUALLY, AS MY WATCH CLEARLY INDICATES."**



# Questions



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# Discussion



# Contacts

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