

NATIONAL CONSENSUS STANDARDS FOR SAFER HEALTHCARE

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**“Medicine used to be simple,
ineffective and relatively safe.
Now it is complex, effective
and potentially dangerous.”**

Sir Cyril Chantler, former Dean
Guy's, King and St. Thomas's Medical
and Dental School, *Lancet* 1999

Presentation Overview

- The occurrence of medical errors
- What is the NQF
- NQF activities in patient safety
 - ✓ Priority strategic actions
 - ✓ Serious Reportable Events
 - ✓ 'Safe Practices'
 - ✓ Patient Safety Taxonomy
 - ✓ Performance measures

*WHAT DO WE KNOW ABOUT
THE OCCURRENCE OF
MEDICAL ERRORS?*

Healthcare Errors – Not a New Problem

“I would give great praise to the physician whose mistakes are small for perfect accuracy is seldom to be seen”

Hippocrates

Healthcare Errors – Not a New Problem

“... even admitting to the full extent the great value of the hospital improvements in recent years, a vast deal of the suffering, and some at least of the mortality, in these establishments is avoidable.”

Florence Nightingale, 1863

Healthcare Errors – Not a New Problem

“...Serious and widespread quality problems exist throughout American medicine. These problems...occur in small and large communities alike, in all parts of the country, and with approximately equal frequency in managed care and fee-for-service systems of care. Very large numbers of Americans are harmed as a direct result...”

IOM National Roundtable on
Health Care Quality, 1998



"Your skin is enlarged."

Code Words for Medical Errors

- Adverse event, adverse outcome
- Medical mishap; unintended consequence
- Unplanned clinical occurrence; unexpected occurrence; untoward incident
- Therapeutic misadventure; bad call
- Peri-therapeutic accident
- Sentinel event
- Iatrogenic complication/ injury
- Hospital acquired complication

Healthcare Errors – How Big is the Problem?

- 3-38% of hospitalized patients affected by iatrogenic injury or illness
- 44,000-98,000 hospital deaths/year (IOM)
- 2-35% of hospitalized patients suffer adverse drug events (average 7%)
- >7,000 ADE deaths/year
- 2 million nosocomial infections/year

What is the role of the
NATIONAL QUALITY FORUM?

WHAT IS THE NQF?

The National Quality Forum is
a private, non-profit
voluntary consensus standards
setting organization.

WHAT DOES THE NQF DO?

The NQF was established to improve the quality of U.S. health care by:

- standardizing health care performance measurement and reporting;
- designing an overall strategy and framework for a National Healthcare Quality Measurement and Reporting System; and
- otherwise promoting, guiding and leading health care quality improvement.

HISTORY

- **Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry established (1996)**
- **Commission recommended the creation of a private sector entity (“Quality Forum”) that would bring healthcare stakeholder sectors together to standardize health care performance measures and standards (1998)**
- **Quality Forum Planning Committee convened by White House (1998)**
- **NQF incorporated in District of Columbia (1999)**
- **NQF operational (2000)**

NQF Membership

- Broad membership (nearly 200 organizations, May 2003)
- An “organization of organizations”
- 4 Member Councils
 - Consumers
 - Health care providers and health plans
 - Purchasers
 - Research and quality improvement organizations

Board of Directors

- **Board of Directors composed of 23 voting members**
 - ✓ The CEOs of 3 federal agencies (CMS, OPM and AHRQ)
 - ✓ Representatives of state health officers and Medicaid
 - ✓ Private sector representatives
- **6 liaison members (JCAHO, NCQA, IOM, NIH, FACCT and PCPI-AMA)**
- **Consumers and purchasers constitute a majority**

NQF: UNIQUE FEATURES

- **Open membership**
- **Public and private sector representation on governing board**
- **Equitable status of stakeholder sectors (member councils)**
- **Attention to overall strategy for measuring and reporting healthcare quality, including establishing national goals**
- **Focus is on the entire continuum of healthcare**
- **Formal consensus process (“voluntary consensus standards”)**

NQF: An Experiment in Democracy

- **Equitable decision making among stakeholder sectors**
- **Balancing self-interest with the public good**
- **Government-private sector partnership**

National Technology and Transfer Advancement of Act of 1995 (NTTAA)

- Defines the 5 key standards body” (i.e., openness, balance of interest attributes of a “voluntary consensus, due process, consensus, and an appeals process)
- Obligates federal government to adopt voluntary consensus standards (when the government is adopting standards)
- Encourages federal government to participate in setting voluntary consensus standards

SELECTED PROJECTS

- **Serious Reportable Adverse Events**
- **Safe Practices**
- **Diabetes Management National Consensus Standards**
- **Hospital Care National Performance Measures**
- **Nursing Home Care Performance Measures**
- **Home Health Care Performance Measures**

SELECTED PROJECTS

- Cancer Care Quality Measures
- Mammography Standards for Consumers
- Cardiac Surgery Performance Measures
- Nursing Care Performance Measures
- Patient Safety Taxonomy
- Standardizing Credentialing
- Behavioral Health Care Performance Measures

NQF AND PATIENT SAFETY

**High quality care begins with
ensuring safe care!**

STRATEGIC ACTIONS:
A Consensus Statement

Patient Safety: A Call to Action

Priority Strategic Action Areas

- Leadership engagement
- Organizational commitment
- Safety Audits
- Promote a culture of safety
- Implement “safe practices”
- Patient safety education
- Accountability
- Professional misconduct
- Research
- Non-punitive error reporting

Patient Safety Improvement Strategies

ERROR REPORTING: Serious Reportable Events (“Never Events”)

SERIOUS REPORTABLE EVENTS IN HEALTHCARE PROJECT

The objective of the *Serious Reportable Events Project* was to reach agreement about a set of serious, preventable adverse events that might form the basis for a national state-based healthcare error reporting system and that could lead to substantial improvements in patient care.

SERIOUS REPORTABLE EVENTS

- **Surgical events (5)**
- **Product or device events (3)**
- **Patient protection events ((3)**
- **Care management events (7)**
- **Environmental events (5)**
- **Criminal events (4)**

SERIOUS REPORTABLE EVENTS

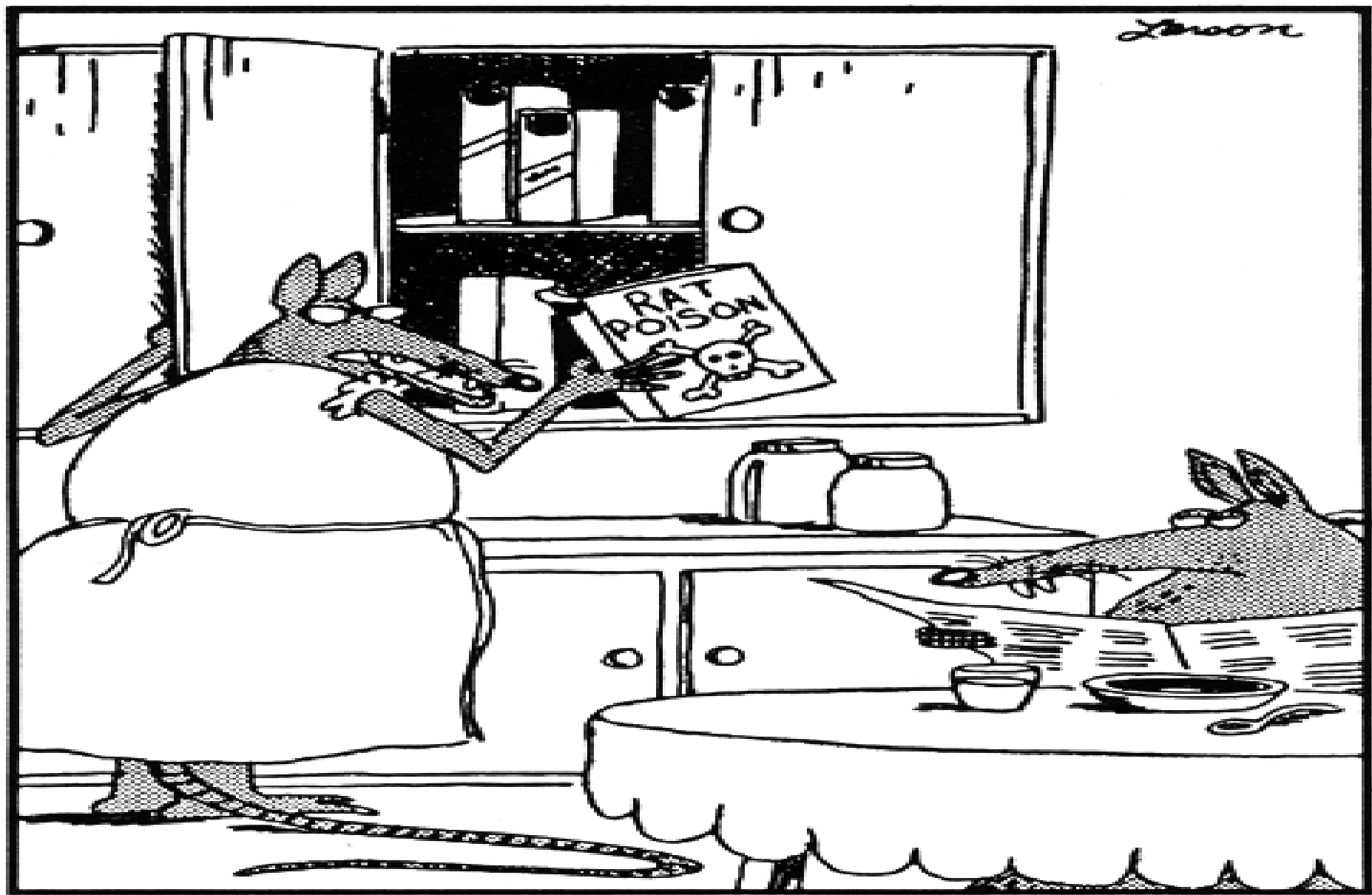
- **Minnesota's new Adverse Health Events Reporting Law**
- **Other states considering use of the SRE list**
- **DOD TRICARE reporting requirement**

Patient Safety Improvement Strategies

STANDARDIZING THE PATIENT SAFETY TAXONOMY

Patient Safety Improvement Strategies

IMPLEMENT SAFE PRACTICES



“You know, it’s really dumb to keep this right next to the cereal. ... In fact, I don’t know why we even keep this stuff around in the first place.”

SAFE PRACTICES Project: Purpose

- To identify evidence-based health care practices (“safe practices”) which would significantly improve patient safety if universally implemented.
- To stimulate “buy in” and adoption of or compliance with these practices

SAFE PRACTICES – Sources of Candidate Practices

- **AHRQ EPC Report No. 43**
- **Medical specialty societies**
- **Pharmacy organizations**
- **Nursing Associations**
- **NQF Membership**
- **Safe Practices Steering Committee**

SAFE PRACTICES - Inclusion Criteria

- **Specificity**
- **Effectiveness**
- **Benefit**
- **Generalizability**
- **Readiness**

SAFE PRACTICES - Categories

- I.** Create a culture of safety
- II.** Match care needs with service capability
- III.** Facilitate information transfer and clear communication
- IV.** Enhance the safety of specific processes or settings of care
- V.** Increase safe medication use

Create a Culture of Safety

Culture - Definition

The predominating attitudes and behavior that characterize the functioning of a group or organization

... American Heritage Dictionary, 2000

Healthcare's Historical Culture

- **Combination of art and science**
- **Highly individualistic**
- **Competitive**
- *Ad hoc* **organization**
- **Focus on perfection (not excellence)**

CULTURE OF SAFETY - DEFINITION

A healthcare culture of safety is an integrated pattern of individual and organizational behavior, based upon shared beliefs and values, that continuously seeks to minimize patient harm which may result from the processes of care delivery.

CULTURE OF SAFETY - BELIEFS AND VALUES

- **Modern healthcare is highly complex; because of this complexity, it is error-prone, and high-risk**
- **Errors are inevitable when humans are involved**
- **Hazards and errors can be anticipated and systems designed both to prevent human errors and to prevent patient harm if an error occurs**

CULTURE OF SAFETY - BELIEFS AND VALUES

- Safety is a system property; it is a product of the interaction of individual, technical, organizational, regulatory and economic factors
- Improving safety is everyone's job, and ensuring safety should be job #1

The 5 C's of a Healthcare Culture of Safety?

- **Competence**
- **Communication**
- **Collaboration and Coordination**
- **Compassion**

CULTURE OF SAFETY - COMPETENCE

- **Knowledge and skills are foundational (but not sufficient)**
 - ✓ Individual caregiver
 - ✓ Organizational
 - ✓ Cultural
- **Competence is ephemeral and must be actively managed**
- **Healthcare education generally does not address many subjects important to patient safety**

Patient Safety Education Needs

- **Teamwork concepts**
- **Human factors and performance**
- **Incident analysis**
- **Complexity theory**
- **Information management**
- **Communication skills**
- **Quality management**

CULTURE OF SAFETY - COLLABORATION AND COORDINATION

Necessary at each stage of system activity:

- Design
- Construction
- Maintenance
- Allocation of resources
- Training
- Educational and developing operational procedures
- Execution of procedures

CULTURE OF SAFETY - DESIGN FOR COLLABORATION AND COORDINATION

Design work so that it is easy to do
it right and hard to do it wrong

CULTURE OF SAFETY - DESIGN MANAGEMENT

- 1. Reduce reliance on memory**
- 2. Simplify processes (reduce steps)**
- 3. Standardize**
- 4. Utilize constraints and forcing functions**
- 5. Use protocols and checklists**

CULTURE OF SAFETY - DESIGN MANAGEMENT

6. Recognize fatigue's effect on performance
7. Require education and training for safety
8. Promote teamwork
9. Reduce known sources of confusion
10. Align incentives and rewards

CULTURE OF SAFETY - COMPASSION

- 1. Acknowledge any and all errors that cause harm**
- 2. Apologize; say you are sorry**
- 3. Provide restorative or remedial care**
- 4. Conduct root cause analysis**
- 5. Fix system or process problems**

SAFE PRACTICES: Essential Elements of a Culture of Safety

In a Culture of Safety there are standard methods to:

- Prioritize events to be reported*
- Analyzing reported events*
- Verify remedial actions taken
- Ensure leadership involvement

*all predicated on having a nonpunitive environment

SAFE PRACTICES: Essential Elements of a Culture of Safety

In a Culture of Safety there are standard methods to:

- Provide oversight and coordination
- Provide feedback to frontline*
- Publicly disclose compliance
- Train staff in teamwork-based problem solving

*all predicated on having a nonpunitive environment



"No, I haven't performed the procedure myself, but I've seen it done successfully on 'E.R.' and 'Chicago Hope.'"

SAFE PRACTICES: Matching Care Need With Service Capability

- Refer designated high-risk, elective surgical procedures or other specified treatments to hospitals that are likely to produce the best outcomes.

Demonstrated Volume-Outcome Relationship

- Coronary artery bypass grafts
- Angioplasty
- Abdominal aortic aneurysm repair
- Pancreatectomy
- Esophageal cancer surgery
- Delivery of LBW baby <1500 gms and/or <32 wks gestation
- Delivery of baby with major congenital malformations

SAFE PRACTICES: Matching Care Need With Service Capability

- Use intensivists to manage ICU patients
- Pharmacists should participate in all stages of the medication use process
- Use an explicit protocol for nurse staffing based on patient mix and staff skills

DOES THIS LOOK
LIKE 'ASPIRIN'
OR 'ARSENIC'
TO YOU?

TAKE R_x

M.D.
ERRORS
↑



SAFE PRACTICES: Facilitating Information Transfer and Clear Communication

- Use repeat back for verbal orders
- Use only standardized abbreviations and dose designations
- Use original source documents when preparing records (do not rely on memory)
- Make complete record available whenever there is a "handoff" (change of caregivers)

SAFE PRACTICES: Facilitating Information Transfer and Clear Communication

- Ensure care information (esp change of orders, new dx data) is transmitted in a clearly understandable form to all of the patient's caregivers (including OP)
- Informed consent forms should be "user friendly"
- Prominently display in chart patient's preference for life sustaining treatment
- Utilize computerized prescriber order entry

CPOE Specifications

Prescribers enter hospital medication orders via an automated information management system that is:

- Linked to prescribing error prevention software
- Enables review of all new orders by a pharmacist before first dose
- Permits notation of allergies in one place
- Categorizes drugs into “drug families” to allow checking within classes
- Requires documentation of overrides
- Internal automatic performance checks of the information system

SAFE PRACTICES: Facilitating Information Transfer and Clear Communication

- Utilize a standard protocol for labeling radiographs
- Utilize a standard protocol to prevent wrong site or wrong person surgery

Prevention of Wrong Site Surgery

- Documentation of operative site in the patient's record
- Patient's record in OR
- OR team verifies operative site and document verification
- Whenever possible, patient also verifies operative site in OR, and this is documented

SAFE PRACTICES: Specific Settings or Processes of Care

Utilize a standard protocol to evaluate each patient for their risk of and that uses effective methods to prevent:

- Intra-operative cardiac ischemia
- Pressure ulcers
- Venous thromboembolism
- Aspiration
- Central venous catheter-related infections

SAFE PRACTICES: Specific Settings or Processes of Care

Utilize a standard protocol to evaluate each patient for their risk of and that uses effective methods to prevent:

- Surgical site infection
- Contrast media-induced nephropathy
- Malnutrition
- Pneumatic tourniquet-induced ischemia or thrombosis

SAFE PRACTICES: Specific Settings or Processes of Care

- Decontaminate hands prior to and between each patient encounter
- Vaccinate all care personnel against influenza
- Use dedicated anticoagulation services that facilitate coordinated care management

SAFE PRACTICES: Promoting Safe Medication Use

- **Keep medication preparation areas orderly, well lit, and free of clutter, distraction and noise**
- **Standardize methods of labeling, packaging and storing medications**
- **Identify all “high alert” drugs in use and utilize standard procedures in their use**
- **Dispense medications in unit-of-use form whenever possible**

MORE INFORMATION...

www.qualityforum.org

**High quality care begins
with ensuring safe care!**

“Grant me the courage to realize my daily mistakes so that tomorrow I shall be able to see and understand in a better light what I could not comprehend in the dim light of yesterday”

Maimonides (1135-1204)