What Every Patient Safety Officer Must Know:

Tapping into the Best Resources in the Country

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The Hospital & Healthsystem Association of Pennsylvania

Overview

- Role of Patient Safety Officers
- What PSOs Work On
- Areas of Interest
  - Disclosure
  - Medication Safety
  - Patient Safety Culture
- Future Roles

PSO Roles

Systemic Migration to Boundaries

VERY UNSAFE SPACE

'Illegal normal'
Real life standards

Safety Regs
& good practices
Certification/ accreditation standards

BTCUs
Border-Line
tolerated Conditions
of Use

Usual Space
Of Action

Expected safe
space of
action
as defined by
professional
standards

ACCIDENT

Adapted from R. Amalberti

PERFORMANCE

Patient Safety Officer Pennsylvania

Patient Safety Officer must:

- Serve on the patient safety committee
- Ensure investigation of all reports
- Take necessary and immediate action to ensure patient safety as a result of investigation
- Report to patient safety committee action taken to promote patient safety

Patient Safety Officer Qualifications

- RN, MD, Risk Manager or Attorney. Consider advanced degree in Public Health, Epidemiology, or other healthcare related field.
- Experience with the organization's identified Quality Improvement Model/Program
- Knowledge of risk management principles and issues regarding patient safety.
- Strong leadership qualities and effective change agent

Patient Safety Officer Reporting Relationships

- Serve as liaison between the CEO, the Board of Trustees, the Medical Staff and the Patient Safety committee
- Visible to the Organization
- Report up to the Highest level of the Organization
- Ability to directly advise the CEO

Areas of Responsibility

Current Focus of Patient Safety Programs

Focus	%
Written notification/disclosure of serious events	98%
Medication management processes	94%
Wrong patient, surgery, site protocol	86%
Reducing hospital-acquired infections	86%
Verbal/written communication policies	78%
Patient/family involvement	72%
ICU safety programs	33%
Individual accountability programs	32%
Computerized physician order entry	18%
Point-of-care bar-coding	17%
Other	7%

Source: HAP Member Survey of Patient Safety Officers, April 2004

Planned Components of Patient Safety Programs

Component	Percent
Point-of-care bar-coding	53%
Computerized physician order entry	47%
ICU safety programs	28%
Individual accountability programs	25%
Patient/family involvement	23%
Verbal/written communication policies	9%
Reducing hospital-acquired infections	7%
Medication management processes	4%
Written notification/disclosure of serious events	2%
Wrong patient, surgery, site protocol	1%

Source: HAP Member Survey of Patient Safety Officers, April 2004

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Issues Addressed at Patient Safety Committees

Issue	%
Revision of policies	96%
Investigation of Events by PSO	94%
Employee education	92%
Patient safety reports to Board	89%
Review of root cause analysis	88%
Written notification or disclosure	85%
Medical staff education	82%
Review of failure mode effects analysis	79%
Classification of reportable events	75%
Review of patient/staff surveys	72%
Disciplinary action policies	30%
Other	12%

Source: HAP Member Survey of Patient Safety Officers, April 2004

Disclosure of Unanticipated Events

General Considerations…

Disclosure

- Not an admission of liability
- Not easy on provider/patient/family/staff
- Provide education for providers on “how to”
- Allow for situations where disclosure may be more harmful than beneficial for patient
- Stress importance of informed consent as a risk reduction tool

…General Considerations…

Disclosure

- Physician generally best person
- Circumstances may require a substitute
  - if decide other than MD - rethink decision - it may send a message different than what intended
  - should be individual who can convey concern sincerely
  - who decides substitute and what criteria used to decide?
  - how respond to questions about future care needed as result of medical mistake if not physician?
  - how ensure physician not implicated in discussion?

…General Considerations

Disclosure

- **If do not yet know the reason why the mistake occurred or don't have an answer – be honest**
  - Admit do not have all the answers yet willing to share them with patient when known
  - Avoid putting patient in spot where they speculate and provide their own answers – can be worse than reality
- **May need to ask patient/family to trust you to do your job – to get to the bottom of the matter**

Steps in Disclosing Medical Errors…

- “Show up” in a Timely Manner
- Begin by Expressing Empathy for the Patient/Family Experience Accurately Describe the Situation, the Error and How You Believe It Impacted the Patient
- Offer an Apology (Apology begins the process of re-affiliation with the patient)

…Steps in Disclosing Medical Errors

- Explain Steps to Prevent Recurrence
- Arrange Congenial and Thorough Follow-up, Sharing this Decision with Patient/Family
- Communicate Closely with Other Providers about What You Believe Has Happened and What Steps are Needed Now to Restore Patient to Health
- Arrange for Bills Related to Care to Be Handled and Assure Patient of This

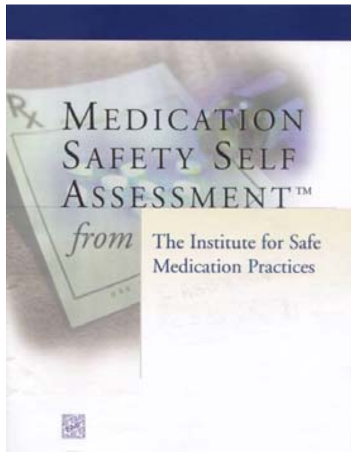
Resources

- **ASHRM's** ***Perspective on Disclosure of Unanticipated Outcome Information***

Found At
http://www.aha.org/aha/key_issues/patient_safety/contents/unanticipatedoutcomes.pdf

Medication Safety

ISMP Self Assessment Tool



- Innovative practices and system enhancements
- A baseline measurement
- Foundation for strategic planning

Greatest Opportunities

- Patient Information
- Communication of Drug Information
- Patient Education
- Quality Process and Risk Management
- Drug Information
- Staff Competency and Education

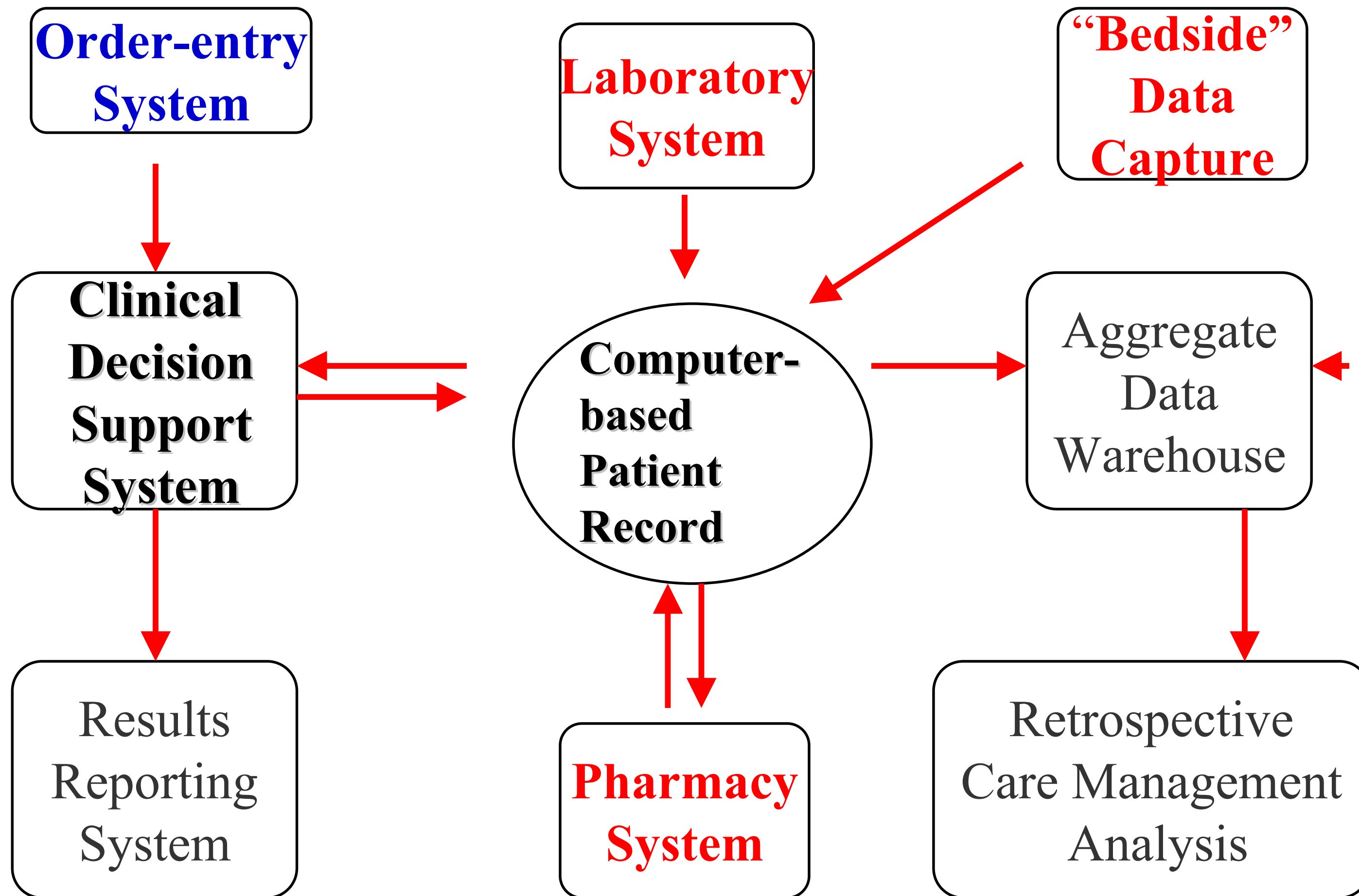
Medication Safety Tools

- *Pathways for Medication Safety*
- AHA/HRET Initiative
  - In Collaboration with ISMP and Based on Self-assessment Results
  - Supported by Commonwealth Fund
- Three Tools
  - Patient Safety Strategic Planning
  - Proactive Hazard Analysis
  - Bar Coding Readiness Assessment

For More Information

- Pathways for Medication Safety **www.medpathways.info**
- Free tools available for download off the web
- Please send questions to **medpathways@aha.org**

Information Systems and a Safer Medication System



Assessing Bedside Bar-Coding Readiness

- Explains the role of bar coding technology from a health care context.
- Describes benefits and challenges of implementation.
- Includes a self-assessment tool to evaluate an organization's "readiness" for implementation.

Barcode Implementation Guidance

- **HIMSS**
  Implementation Guide for the Use of Bar Code Technology in Healthcare

- **HRET**
  Study of Implementation Barriers and Facilitators

CPOE Resources

- *A Primer on Physician Order Entry*
  California HealthCare Foundation
  September 2000
- *Computerized Physician Order Entry: Costs, Benefits and Challenges*
  First Consulting Group, AHA, Federation of American Hospitals
  January 2003

Expanded Culture of Safety

What is "Culture"?

- "Shared <u>values</u> (what is important) and <u>beliefs</u> (how things work) that interact with an organization's structures and control systems to produce <u>behavioral norms</u> (the way we do things around here)"

B. Uttal, Fortune, 17 October, 1983

Current Concepts of Safety Culture in Healthcare

- Health care has discussed a "safety culture" primarily as issues of {per Reason}:
  - A non-punitive "just culture"
  - A "reporting culture"
- These are important, but they ignore other crucial aspects of a culture of safety

Culture of Safety

- **Based on the Concept of Mindfulness**

  "the combination of ongoing scrutiny of existing expectations, continuous refinement…based on newer experience, willingness and capability to invent new expectations…, a more nuanced appreciation of context…[resulting in] improve(d) foresight and current functioning"

Weick and Sutcliffe

Culture of Safety

- Anticipating
  - Preoccupation with Failure
  - Reluctance to Simplify Interpretations
  - Sensitivity to Operations
- Containing
  - Commitment to Resilience
  - Deference to Expertise

Weick and Sutcliffe

The Case for Leadership

- Lessons from Human Space Flight and Aviation
- Skills and Competencies to Manage Hazard
  - Human Factors
  - Behavioral Norms
  - Communication and Teamwork
  - Crisis Management
  - Proactively Managing Hazard
  - Training for the Unexpected

Identified Skill Gaps

- Incorporating Human Factors in Design
- Teamwork and Communications
- Training for the Unexpected
  - Simulation Training
    - Skills
    - Resiliency

Summary

- Creating Systemic "Mindfulness" about Safety
- Transforming Healthcare Organizations into HROs
- Creating Individual, Team and Organizational Awareness and Resiliency
- New Leadership Skills Required

Supplementary Reading

Gaba D: Structural and Organizational Issues in Patient Safety: A Comparison of Health Care to Other High-Hazard Industries. California Management Review, Fall 2000

Reason J: Managing the risks of organizational accidents. Aldershot, England, Ashgate Publishing Limited, 1997

Sagan S: The Limits of Safety. Princeton, Princeton University Press, 1993

Supplementary Reading

Singer SJ, et al.: The culture of safety: results of an organization-wide survey in 15 California hospitals. Qual Saf Health Care 2003; 12: 112-118

Weick K, Sutcliffe KM: Managing the unexpected. San Francisco, Jossey-Bass, 2001

Future Activities

Safety Initiative: Future Activities

- Nosocomial Infections as Safety Issues
- Team and Reliability Training
  - techniques
  - e.g. simulators
- Communication Skills for Clinicians
  - Improved compliance
  - Better clinical outcomes
- IT Infrastructure

Sharing Knowledge

- Web Site at www.aha.org
- Key Issues: Quality and Patient Safety
  - Tools and Resources
  - IOM's Six Goals