

# **The Quality Colloquium**

**August 20, 2006**

# **Patient Safety Tool Kit**

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Director, Rapid Improvement Program

Premier, Inc

## Themes...

- Data/information/transparency
- Evidence/knowledge/knowledge transfer
- Culture
- Tools/resources

## Who are we....

- **Informaticists**
- **Clinicians and Clinical Consultants and Analysts**
- **Operational & Supply Chain Consultants and Analysts**
- **Management and Industrial Engineers**
- **Contracting & Negotiation Specialists**
- **Risk Managers, Safety & Loss Prevention Specialists**
- **Purveyor of Insurance products**
- **Researchers**
- **Educators/Knowledge Transfer Specialists**

## Data/information/transparency

- You manage what you measure
- Healthcare Informatics is a core competency of Premier
- We can demonstrate good quality costs less (and [leap of faith here] is safer; at minimum is more “defensible”)

## Evidence/knowledge/knowledge transfer

- Evidence must trump habit-based practice, tradition or ritual
- Reinventing the wheel is not a good use of time (knowledge transfer is a component of Premier's enabling infrastructure)
- We partner with Zynx for referential content and physician orders and nursing plans of care

## Culture

- “The way we do things around here...” B. Sexton
- “Culture eats strategy for lunch” D. Pryor
- “Patient Safety Culture Survey”
  - Premier partnered with Agency for Healthcare Research & Quality (AHRQ) – we also translated it into Spanish
  - *You manage what you measure...*

# Resources & Tools: Patient Safety “Tool Kit”

*“The what’s & why’s, but more importantly, the how’s”*

## Safety Institute

- Established in 1999 to fulfill Premier's vision to improve safety among
  - Patients
  - Workers
  - Environment
  - Products



Harvard Medical School  
Department of Continuing Education

October 20 - 21, 2005

# The Patient Safety Imperative

- Sheraton Boston Hotel
- Boston, Massachusetts
- Course Directors:  
Saul N. Weingart, MD, PhD  
David W. Bates, MD, MSc  
Hans Kim, MD, MPH



Dana-Farber Cancer Institute  
Center for Patient Safety



Brigham and Women's Hospital  
Department of Medicine and  
Center of Excellence for Patient Safety  
Research and Practice



Beth Israel Deaconess Medical Center  
Department of Medicine

Pages

Attachments

Comments

6.00 x 9.00 in

### RATIONALE

Patient safety emerged as a major public health issue with the December 1999 Institute of Medicine report, *To Err is Human*. Since that time, there has been significant interest in the problem of medical error and patient safety in the lay media and medical literature. In addition, organizations such as the Massachusetts and American Hospital Associations, the National Quality Forum, and the US Agency for Healthcare Research and Quality have issued "best practice" recommendations for patient safety. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has outlined patient safety requirements for hospital accreditation, including surgical site marking and patient identity-checking. Finally, the Accreditation Council for Graduate Medical Education has implemented required competencies for graduates of all US residency programs in systems-based learning and improvement – topics intertwined with patient safety science.

Medical error is also a major liability risk for health care insurers. Misdiagnoses and delayed diagnoses are among the fastest growing areas of exposure for physicians in ambulatory care. Surgical, anesthesia, and ob-gyn errors also account for a disproportionate share of large malpractice awards.

### COURSE OBJECTIVES

- To understand the patient and provider experience of medical error
- To update learners' knowledge about the prevalence of medical error among at-risk populations and high-hazard settings
- To understand alternative methods for identifying errors and injuries
- To use root-cause analysis and failure mode and effects analysis
- To apply human factors principles to prevent medical errors
- To examine and practice techniques for improving patient safety
- To recognize the need for disclosure of errors and accidents and to develop skills in making disclosures
- To develop strategies for improving patient safety in one's own practice

### AUDIENCE

This is a course designed for practicing physicians. The course will also interest medical educators, medical practice directors, nurses, pharmacists, risk managers, quality improvement professionals, health administrators, and health services researchers. Specialist groups in high-risk areas such as oncologists, critical care doctors (anesthesia, pulmonary, neonatology), emergency physicians, and hospitalists may find this course particularly useful.

### COURSE DIRECTORS

**Saul N. Weingart, MD, PhD**  
Vice-President for Patient Safety, Dana-Farber Cancer Institute;  
Assistant Professor of Medicine, Harvard Medical School

**David W. Bates, MD, MSc**  
Chief, Division of General Internal Medicine,  
Brigham and Women's Hospital;  
Professor of Medicine, Harvard Medical School

**Hans Kim, MD, MPH**  
Medical Director, Clinical Effectiveness, Beth Israel Deaconess  
Medical Center; Instructor of Medicine, Harvard Medical School

**This course is supported by the Safety Institute, Premier Inc.**

### ACCREDITATION

Harvard Medical School is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Harvard Medical School designates this educational activity for a maximum of 14.5 category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

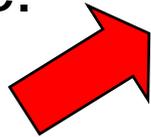
The American Medical Association has determined that physicians not licensed in the US who participate in this CME activity are eligible for AMA PRA category 1 credit

This course awards 14.5 risk management credits. Continuing education credits may also be arranged for nurses.

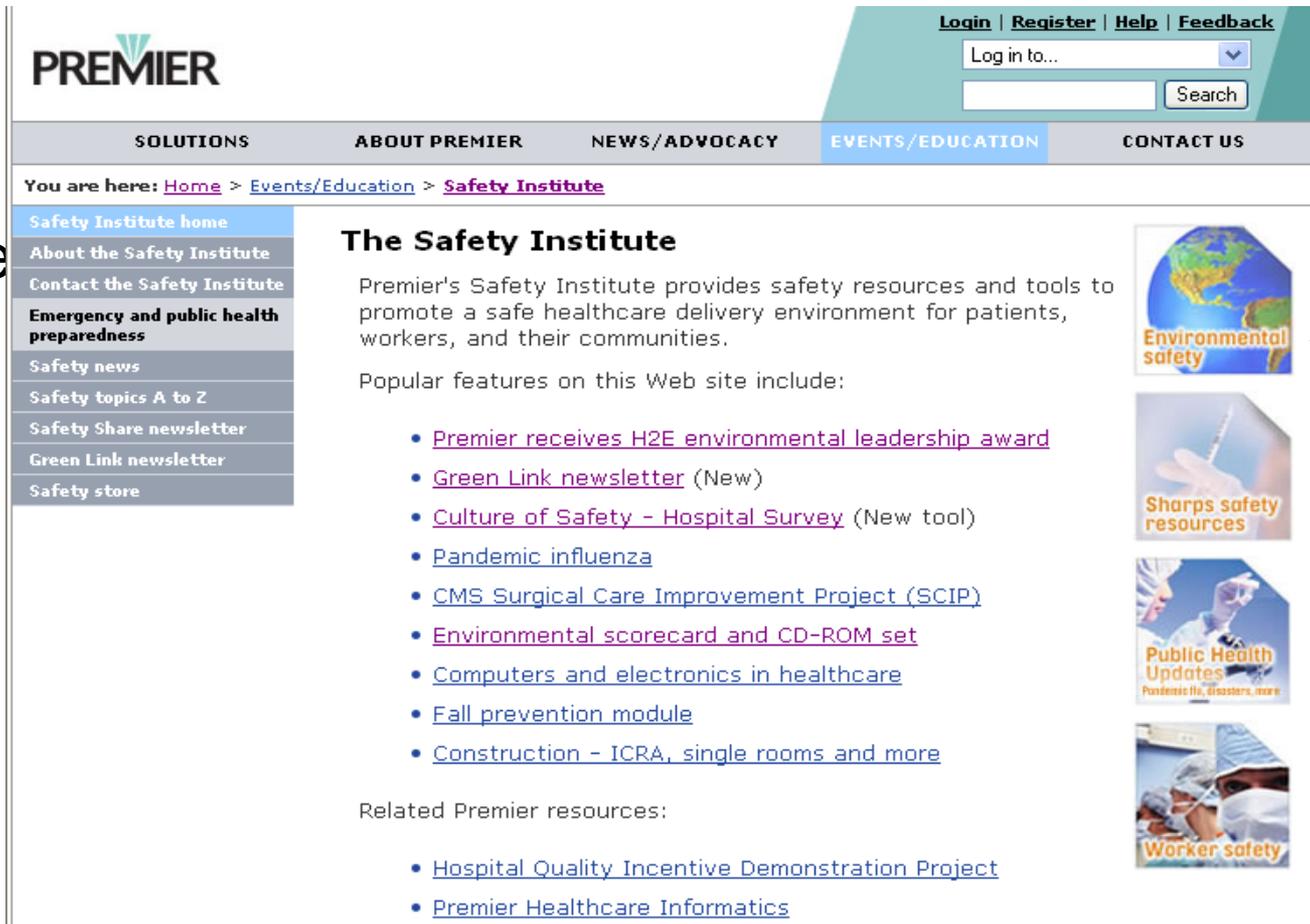
# Safety Web home page

- [www.premierinc.com/safety](http://www.premierinc.com/safety)

Navigate with the links on the left of each page.



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## The Safety Institute

Premier's Safety Institute provides safety resources and tools to promote a safe healthcare delivery environment for patients, workers, and their communities.

Popular features on this Web site include:

- [Premier receives H2E environmental leadership award](#)
- [Green Link newsletter](#) (New)
- [Culture of Safety - Hospital Survey](#) (New tool)
- [Pandemic influenza](#)
- [CMS Surgical Care Improvement Project \(SCIP\)](#)
- [Environmental scorecard and CD-ROM set](#)
- [Computers and electronics in healthcare](#)
- [Fall prevention module](#)
- [Construction - ICRA, single rooms and more](#)

Related Premier resources:

- [Hospital Quality Incentive Demonstration Project](#)
- [Premier Healthcare Informatics](#)

**Environmental safety** 

**Sharps safety resources**

**Public Health Updates**  
 Pandemic H1N1, Disasters, more

**Worker safety**

# Topics on the Safety Web: A to Z

covered in-depth

- Back injury prevention
- Bar Coding and UPN
- Bundling **Coming Soon**
- Cell Phones and EMC
- *Clostridium difficile* **New**
- Computerized physician order entry
- Computers and electronics
- Construction – ICRA
- Culture of Patient Safety **New**
- Disaster Readiness
- Environmentally Preferable Purchasing
- Environmental and Safety Products Lists
- Fall prevention
- Guidelines-Infection Prevention & Safety
- Hand hygiene guideline
- Influenza resources
- Latex Allergies
- Mercury Pollution Prevention
- Occupational TB Risks
- Patient Safety
- Pharmaceutical waste management
- Recalls and product notifications
- Reuse of Single-use Devices
- Sharps Injury Prevention

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**Patient Safety**[Part I - Medical errors and the Institute of Medicine \(IOM\)](#)[Part II - A framework for safety culture and reporting](#)[Part III - Patient Safety and JCAHO](#)[Downloads](#)[Education and training](#)[Key documents](#)[Links](#)[Program tools](#)[Resources](#)[Sample policies](#)[Comments and feedback](#)

## Patient safety

### Summary

- [Part I](#) - Response to Institute of Medicine reports; updates on national safety initiatives from AHRQ, QuIC, Health Leadership Council, Leapfrog, NQF, Veterans Health Administration, ISMP, and more.
- [Part II](#) - Safety culture, error reporting, systems improvement, human factors, engineering.
- [Part III](#) - JCAHO and patient safety, including sentinel events, core measures, and environment of care restraints.

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## Patient safety

### Downloads

### Tools

- [Categorized list of safety tools available free from the Safety Web](#) (344 KB) (.xls)

### AHRQ Evidence Report/Technology Assessment Number 43

*Making Health Care Safer: A Critical Analysis of Patient Safety Practices*

- [Summary](#) (58 KB)
- [Appendix](#) (54 KB)
- [Full report](#) (2107 KB)

### Documents in Microsoft Word format (\*.doc)

- [Avoiding Common Safety Mistakes: Best Practices for a Safer Environment](#). In *Outpatient Surgery*, December 2002.
- [JCAHO National Patient Safety Goals](#)
- [Patient Safety Program Tool Kit for "Getting Started"](#)
- [2002 Premier Policy Position Statement](#)
- [2001 Premier Policy Position Statement and June Update](#)
- [Revisions to Joint Commission Standards in Support of Patient Safety and Medical/Health Care Error Reduction](#)
- [Current Research on Patient Safety in the United States](#)
- [Generic Safety Plan: Template](#)
- [Organized Assignments for Accompanying Patient Safety Plan or Program](#)



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- Informed Consent and the Law Tool Kit
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## Patient safety

### Program tools

### Basic patient safety program tool kit for "getting started"

#### Introduction

The issue of Patient Safety has come to mean many things since the Institute of Medicine published its defining document in November 1999. Patient safety efforts include developing a "safety culture," reducing medical adverse events such as medication errors, and organizing and integrating many other patient safety related activities in healthcare facilities.

Requirements from the JCAHO (new patient safety standards, reporting serious adverse events such as sentinel events) have intensified the need for organizations to review and address the full scope of issues in a comprehensive manner. The intent of the following documents is to provide a few tools to assist organizations in implementation of a patient safety program. These tools are based on tools developed by Tammy Lundstrum, MD, and the DMC Quality program.

#### Program tools

Selected tools are available in the files appended to this document and include a generic system-wide safety program based on a large urban system with multiple care sites. The program or plan is accompanied by several related documents, all of which may be customized as needed.

- A corporate plan, including structure, elements, responsibilities, reporting relationships, documentation, timelines, and confidentiality issues: [BSP Generic Safety Plan.doc](#)
- A PowerPoint slide set that provides a graphic presentation of specific elements of the program, key individuals and committees, and timelines: [BSP Medical Safety Program.ppt](#)
- A sample job description for a Chief Quality and Safety Officer: [BSP Job Description CQSO.doc](#)
- A sample grid for listing committee assignments to document and

## Safety A to Z

# Culture – Patient Safety

- CDs of audioconferences with AHRQ on survey implementation
- Culture survey tool kit
- Culture survey form (in word, pdf, text) (Spanish version)
- Survey feedback template (Powerpoint)
- Premier Customized excel data tool
- Other resources and tools

# Premier customized Excel data tool

March 20, 2006 version

- Use to input raw data
- Display results with graphs and tables by demographics or aggregate
- Analyze results
- Share electronically with staff
- Benchmark results



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Fall prevention

**Introduction and scope**

Extent of the problem in healthcare

Definitions and measurements

Cause of falls

Interventions and prevention strategies

Risk assessment

Comprehensive prevention program

Restraints

Contracted suppliers

Downloads

Education and training

Key documents

Links

Products and equipment

Resources

Sample procedures and tools

Comments and feedback

## Fall prevention

- [JCAHO 2005 National Patient Safety Goals includes fall prevention for multiple sites. Click here!](#)
- [Back injury prevention resources](#)

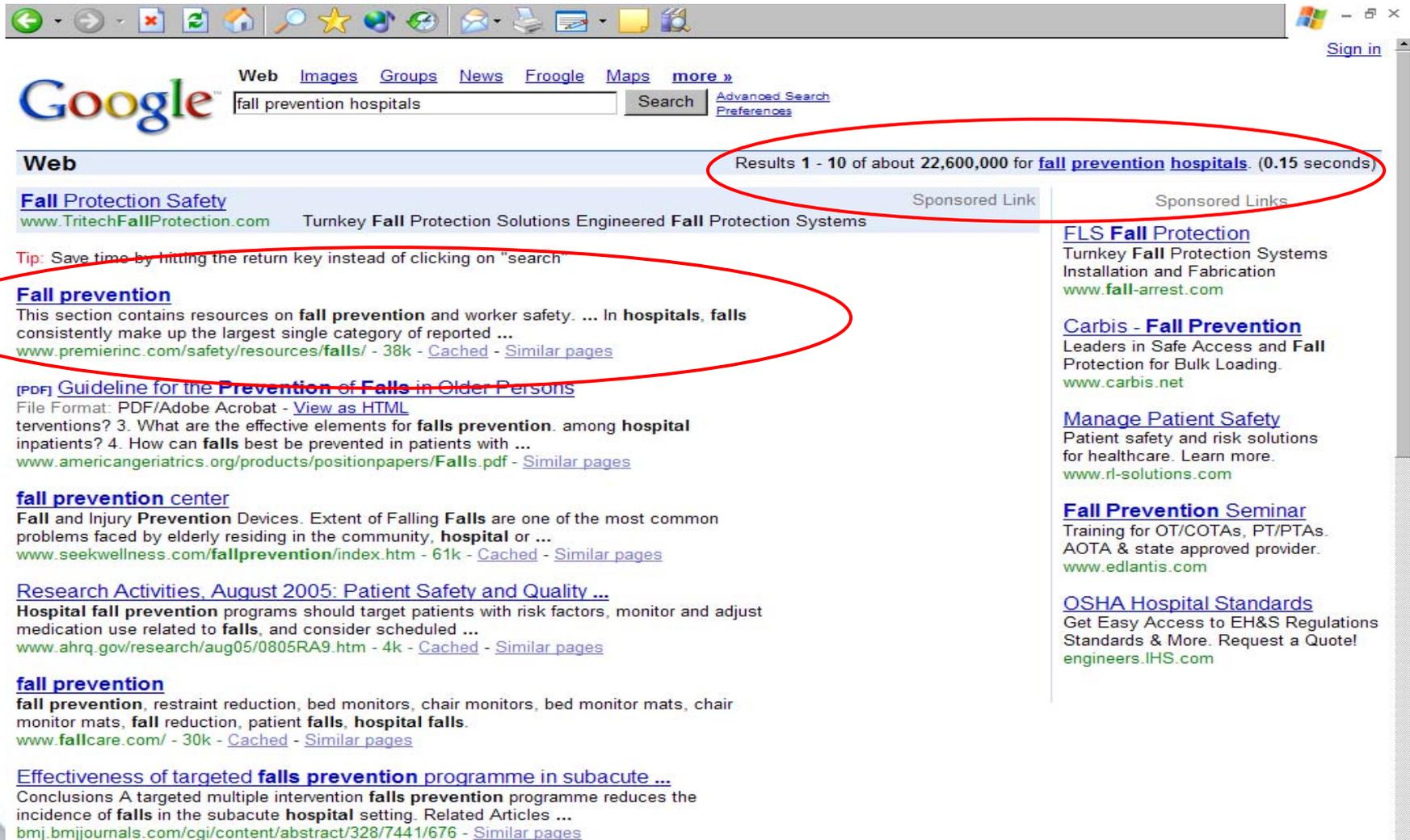
### Introduction and scope

Preventing falls among patients and residents in acute and long term care healthcare settings requires a multifaceted approach, and the recognition, evaluation and prevention of patient or resident falls are significant challenges for all who seek to provide a safe environment in any healthcare setting. It is acknowledged that most of the currently available data, research and guidelines on fall prevention are from long-term care settings; however, much is applicable for all healthcare settings.

This Web site provides a summary of the issues, strategies and tools to define and measure falls, identify risks and target prevention strategies. Each fall prevention program is likely in a different stage of development, whether initiating a new program or expanding or improving an existing program. The content on this site has been organized into sections that focus on specific aspects of a comprehensive falls prevention program. You may wish to review the topic sections that are most relevant to your program development or revision; and include:

- Extent of the problem: incidence and costs of falls.
- Definitions and measurement: trending and benchmarking fall data.
- Causes of falls: information to assist with identification of risks and prevention.
- Interventions and prevention strategies: overview of strategies, including use of sitters.
- Risk assessment: tools for risk and injury assessment.

# Factoid...



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Web Results 1 - 10 of about 22,600,000 for [fall prevention hospitals](#). (0.15 seconds)

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**Fall prevention**  
 This section contains resources on **fall prevention** and worker safety. ... In **hospitals**, **falls** consistently make up the largest single category of reported ...  
[www.premierinc.com/safety/resources/falls/](http://www.premierinc.com/safety/resources/falls/) - 38k - [Cached](#) - [Similar pages](#)

[PDF] [Guideline for the Prevention of Falls in Older Persons](#)  
 File Format: PDF/Adobe Acrobat - [View as HTML](#)  
 interventions? 3. What are the effective elements for **falls prevention**. among **hospital** inpatients? 4. How can **falls** best be prevented in patients with ...  
[www.americangeriatrics.org/products/positionpapers/Falls.pdf](http://www.americangeriatrics.org/products/positionpapers/Falls.pdf) - [Similar pages](#)

[fall prevention center](#)  
**Fall** and Injury **Prevention** Devices. Extent of Falling **Falls** are one of the most common problems faced by elderly residing in the community, **hospital** or ...  
[www.seekwellness.com/fallprevention/index.htm](http://www.seekwellness.com/fallprevention/index.htm) - 61k - [Cached](#) - [Similar pages](#)

[Research Activities, August 2005: Patient Safety and Quality ...](#)  
**Hospital fall prevention** programs should target patients with risk factors, monitor and adjust medication use related to **falls**, and consider scheduled ...  
[www.ahrq.gov/research/aug05/0805RA9.htm](http://www.ahrq.gov/research/aug05/0805RA9.htm) - 4k - [Cached](#) - [Similar pages](#)

[fall prevention](#)  
**fall prevention**, restraint reduction, bed monitors, chair monitors, bed monitor mats, chair monitor mats, **fall** reduction, patient **falls**, **hospital falls**.  
[www.fallcare.com/](http://www.fallcare.com/) - 30k - [Cached](#) - [Similar pages](#)

[Effectiveness of targeted falls prevention programme in subacute ...](#)  
 Conclusions A targeted multiple intervention **falls prevention** programme reduces the incidence of **falls** in the subacute **hospital** setting. Related Articles ...  
[bmj.bmjournals.com/cgi/content/abstract/328/7441/676](http://bmj.bmjournals.com/cgi/content/abstract/328/7441/676) - [Similar pages](#)

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 Turnkey **Fall** Protection Systems Installation and Fabrication  
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**Carbis - Fall Prevention**  
 Leaders in Safe Access and **Fall** Protection for Bulk Loading.  
[www.carbis.net](http://www.carbis.net)

[Manage Patient Safety](#)  
 Patient safety and risk solutions for healthcare. Learn more.  
[www.rl-solutions.com](http://www.rl-solutions.com)

[Fall Prevention Seminar](#)  
 Training for OT/COTAs, PT/PTAs. AOTA & state approved provider.  
[www.edlantis.com](http://www.edlantis.com)

[OSHA Hospital Standards](#)  
 Get Easy Access to EH&S Regulations Standards & More. Request a Quote!  
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# Safety Share

SAFETY NEWS FOR HEALTHCARE

## January 2006

Dear Colleague:

Happy New Year! A reminder: we have [archives](#) of all past issues and the tools featured in *Safety Share* since 2002. Also, visit our [Guidelines section](#), where we have downloadable copies of key safety and infection control guidelines, including the new TB Guidelines just released by CDC.

Sincerely,  
Gina Pugliese, editor  
Vice President, Premier Safety Institute

### News

- [Key to safe insulin use: Top management commitment, resources, and a link to culture of safety efforts](#)
- [Fairview Healthcare Services improves patient and physician satisfaction using Six Sigma](#)
- [CDC recommends use of newer antivirals over resistant Rimantadine, Amantadine](#)
- [Survey on status of patient safety systems shows mixed results](#)
- [CDC updates healthcare TB control guidelines: blood test replaces TB skin test](#)
- [SCIP publishes measurement specifications and additional tools](#)
- [Lack of communication on patient status at 'hand-off' cited as most common reason for adverse events](#)
- [Unplanned post-op admissions to ICU validated as](#)



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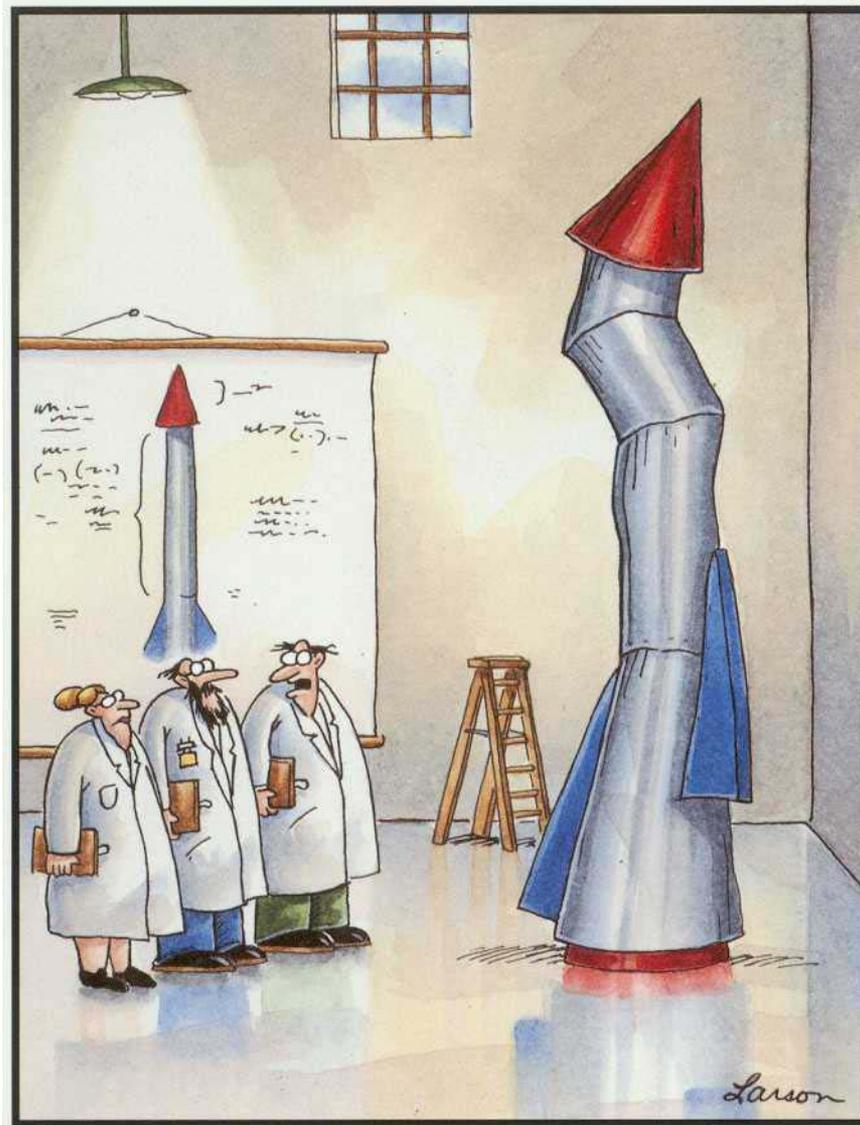
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38,000 subscribers

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tools



"It's time we face reality, my friends. ...  
We're not exactly rocket scientists."

# Questions?

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