Quality and Safety Academy

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

Introductory Series

Session 1: Concepts of Patient Safety

SCHOOL OF MEDICINE

Graduate Medical Education

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

IHQSE

Agenda

1. Introduction and Overview of the QSA
2. Safety Culture
   - Tyler Anstett, DO
3. Reviewing a Safety Event, Errors, & Reporting
   - Emily Gottenborg, MD
4. Care for the Caregiver
   - Sam Porter, MD

Learning Objectives

1. List the components of a Safety Culture.
2. Define Just Culture.
3. Recognize the importance of reporting culture.
4. Describe the process of event review.
5. List cognitive and systems causes of error.
6. Recognize the impact of errors on clinicians.


zoom

No Disclosures

Adapted with permission from: Patrick Kneeland, MD and Stephanie Eldred, MD

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Introductory Series

Fellows Series

Faculty Session

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Introductory Series

Concepts of Patient Safety

QI and Change Management

Finding and Using Your Own Data

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Fellows Series

Foundations of Patient Safety

QI and Change Management

Making QI Academic

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Faculty Session

Coaching and Teaching QI

1999

44K-98K deaths every year due to error

To Err Is Human: Building a Safer Health System. Washington, DC: National Academy Press; 1999.


FIRST, DO NO HARM
TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM
INSTITUTE OF MEDICINE


1993-2018

1999

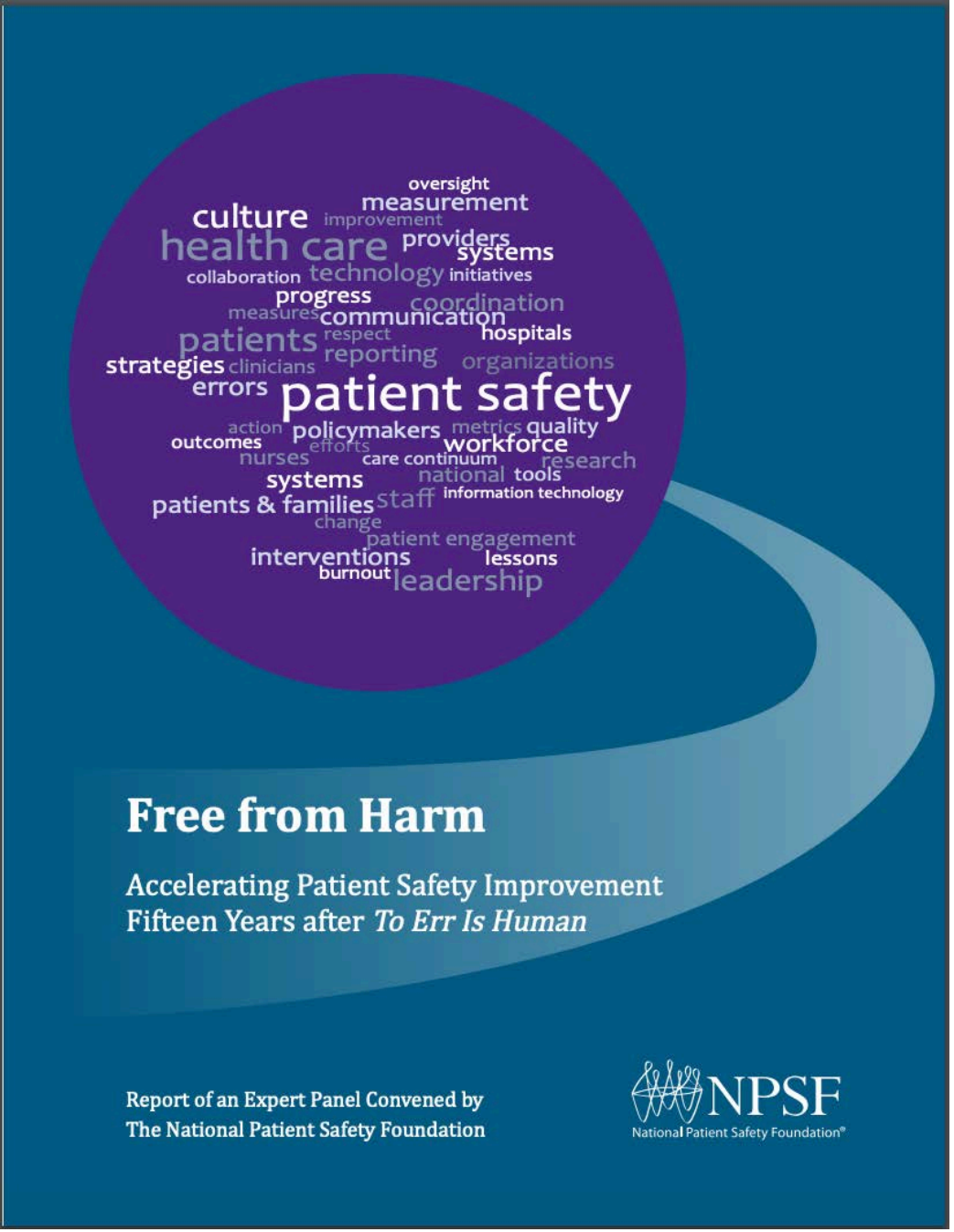
"The status quo is not acceptable and cannot be tolerated any longer."

2016

Medical Error – The Third Leading Cause of Death in the US

Makary MA, Daniel M. Medical error-the third leading cause of death in the US. BMJ. 2016;353:i2139.

Beyond mortality…



1 in 10

Patients develops an adverse event during hospitalization.

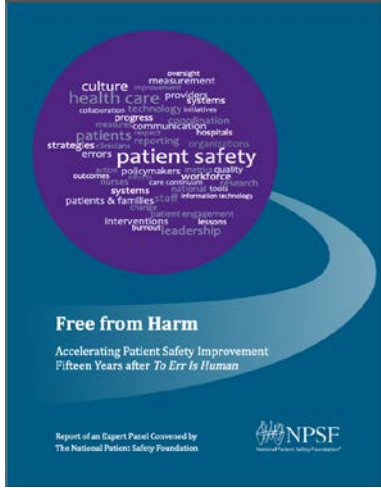
- acquired infection
- pressure ulcer
- preventable adverse drug event

~ 1 in 2

Surgeries had a medication error and/or an adverse drug event.

AHRQ Efforts 2014

Nanji et al. 2015



"A **culture of safety** is fundamental to driving improvements in patient safety…"

SAFETY CULTURE

An informed culture

A reporting culture

A learning culture

A just culture

A flexible culture

Informed Culture

The organization collects and analyzes relevant data, and actively disseminates safety information.

Reporting Culture

An atmosphere where people have confidence to report safety concerns **without fear of blame**.

Employees must know that confidentiality will be maintained and that the **information they submit will be acted upon**, otherwise they will decide that there is no benefit in their reporting.

A Reporting Culture

Safety Reporting - Resources

CLICK HERE TO SUBMIT A PATIENT SAFETY REPORT

uchealth

http://a-rl6.uchealth.org/RL6_Production/Homecenter/Client/Login.aspx?ReturnUrl=/RL6_Production/

Contact:
Vikki.Pope@ucdenver.edu

Children's Hospital Colorado

https://rl6.childrenscolorado.org/RL6_Prod/

Contact:
Nadia.Shuvalova@childrenscolorado.org

DENVER HEALTH

http://psipsi/datix/live/index.php

Contact:
Allison.Hatch@dhha.org
Nathan.Brainard@dhha.org

VA | U.S. Department of Veterans Affairs

https://patientsafety.csd.disa.mil/

Contact:
Germaine.Franciosi@va.gov

Learning Culture

Able to learn from its mistakes and make changes.

Just Culture

Individual practitioners should **NOT** be held accountable for system failings over which they have no control.

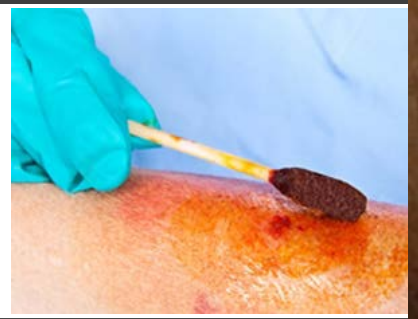
Many individual or “active” errors are due to ***predictable*** interactions between human operators and the systems in which they work.

NOT “NO BLAME”

Human Error	At-risk Behavior	Reckless Behavior
Inadvertent action, slip, lapse, mistake	A choice. Risk not recognized or believed to be justified. Drift.	Conscious disregard of unreasonable risk.
RESPONSE		
Console • Processes • Procedures • Design • Environment • Training	**Coach** • Removing incentives for at-risk behavior • Creating incentives for healthy behaviors • Build systems that support ideal behavior	**Remediation** • Remedial action • Punitive action

Adapted from: James Reason, David Marx, Michael Leonard, Allen Frankel

Human Err s Behavior



Console ediation

- Processes
- Procedures edial action
- Design
- Environme tive action
- Training

Adapted from: James Reason, David Marx, Michael Leonard, Allen Frankel

Flexible Culture

An organization and the people in it can adapt effectively to changing demands.

SAFETY CULTURE

A just culture

↓

A reporting culture

↓

An informed culture

↓

A learning culture → Improvement

A flexible culture → Responsive

https://www.airsafety.aero/Safety-Information-and-Reporting/Safety-Management-Systems/Safety-

James Reason, PhD, CBE

The Bottom Line

There's a lot at stake for patients, providers, and our communities.

Organizations must adopt modern quality improvement tools and methods and train all professionals in safety culture and implementation science throughout their career trajectory.

YOU are a part of **OUR TEAM**.