Patient Safety

Culture, Event Review, Care for the Caregiver

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Agenda

1. Introduction
2. Safety Culture
3. Reviewing a Safety Event, Errors, & Reporting

BREAK

4. Care for the Caregiver

Disclosures

NONE

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

Session	Session Overview
 YOU ARE HERE **Patient Safety**	• Historical origins of patient safety movement • Safety Culture • Case Review • Second victim and how to support caregivers when errors occur
Applied Patient Safety	• Guide the development and participation in a systems-based case review conference.
Quality Improvement & Change Management	• Basics of Quality Improvement • Step-wise, practical implementation guide • Change Management framework overview for driving change
Acquiring Data to Drive Change	• Data sources to track improvement • Data analysis and organization • Data visualization
Spreading Change Locally and Nationally	• Diffusion of innovation framework • QI vs. research • Strategies for dissemination and publication • Grant opportunities
Coaching and Teaching Quality Improvement	• How to coach QI teams • Identifying and troubleshooting common QI missteps

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

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.

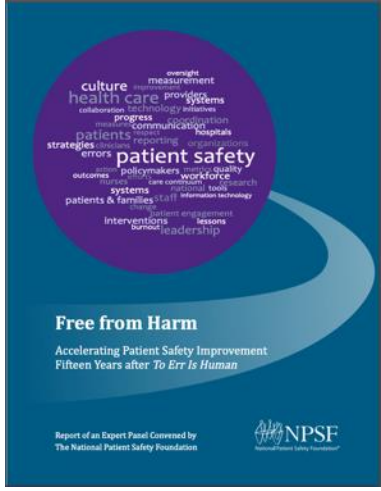
- acquired infection
- pressure ulcer
- preventable adverse drug event

~ 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

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

James Reason, PhD, CBE

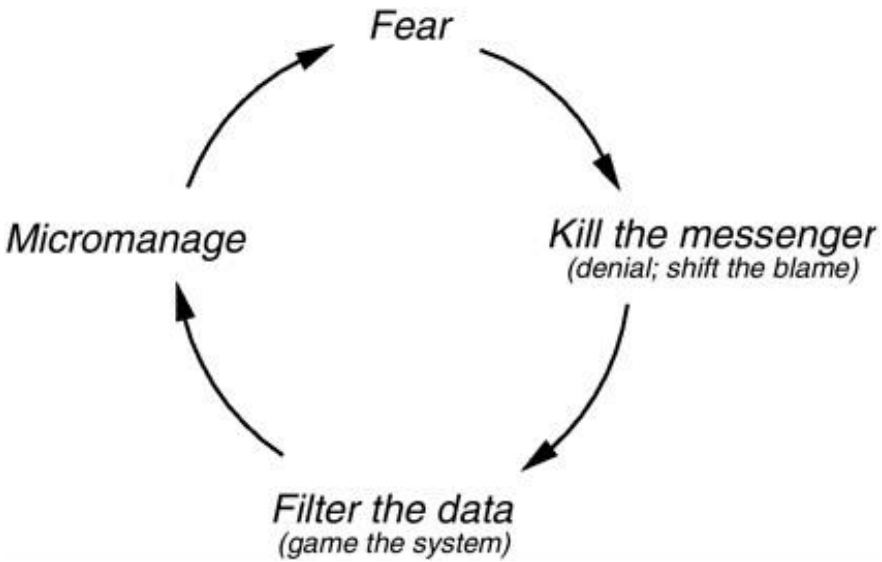
Informed Culture

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.



Scherkenback, 1991

Reporting Culture

UHC Safety Intelligence™
Powered By Datix

RL software for safer healthcare

Performance Health PARTNERS™

PSNet PATIENT SAFETY NETWORK

the patient safety company®
a symplr company

Reporting Culture

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Safety Occurrence Reporting

Why should I report?

Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality.

What should I report?

Incidents: patient safety events that reached the patient, whether or not there was harm involved.

Near misses (or close calls): patient safety events that did not reach the patient.

Unsafe conditions: circumstances that increase the probability of a patient safety event occurring.

What happens to my report?

All safety reports should be reviewed by patient safety specialists at each institution. The reports are then evaluated for potential for harm and if further steps need to be taken to prevent harm in the future.

Will I get in trouble if I report?

NO. The Patient Safety and Quality Improvement Act of 2005 is a federal law that provides legal protection of information voluntarily reported.

PSNet PATIENT SAFETY NETWORK https://psnet.ahrq.gov/primers/primer/13/reporting-patient-safety-events

Why should I report?

What should I report?

What happens to my report?

Will I get in trouble if I report?

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 Er ss Behavior

Inadvertent
action, slip,
lapse, mistak

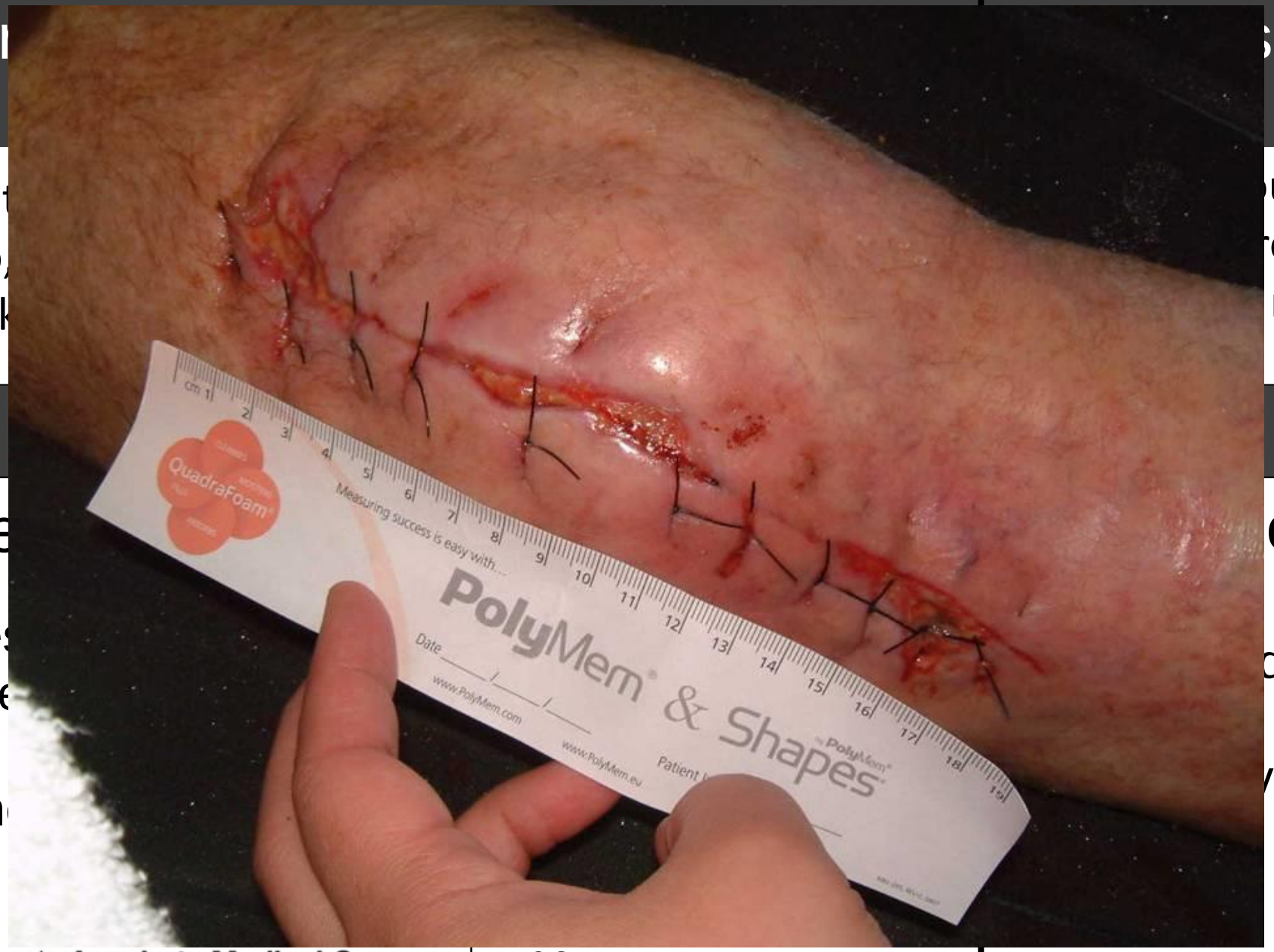
us disregard
easonable
risk.

Console ediation

- Processes
- Procedure
- Design
- Environm
- Training

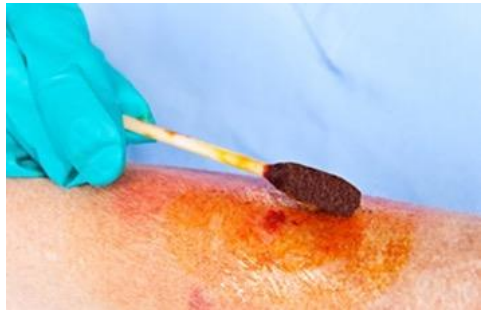
dial action

ve action



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

Human Error



At-risk Behavior

Reckless Behavior

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

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

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 THE TEAM.