focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION

# Patient Safety: A CEO Calls for Leadership

BY JAMES B. CONWAY

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The call is out for health care leadership to take its role in the patient safety movement. Terms such as necessity, urgency, accountability, responsibility, honesty, openness, and visibility appear in the literature[1-8] and are heard from conference podiums nationwide.

This call to action should make a few things clear to health care leaders. First, it suggests that many people don't believe health care leaders are materially concerned about patient safety or, at least not to the degree required today. There is another equally strong message for leadership: your help is wanted and needed.

**Aren't leaders concerned about patient safety?**
The ranks of health care leadership contain extraordinary professionals committed to high-quality care and its continuous improvement. So why do many health care workers believe their leaders are not sufficiently interested in patient safety? There are many reasons, but chief among them is the lack of leadership visibility around error and safety. Outside of "high-level" statements of values, leaders aren't often seen or heard publicly—inside or outside of their institutions—addressing specific trends in system failures.

Fear of embarrassing publicity, risk of a malpractice suit or the lessening of patient and community confidence are often used to explain this lack of openness and visibility. Others believe the absence of candor arises from executives' unawareness of the fragileness of practice in their institutions. Some just attribute it to priority and time.

Whatever the reason, when errors are discovered, orders seem to come down from the top and fact-finding and action planning are done "in secret" in the domain of a select few, all under the notion of "patient confidentiality." In this model, learning about incidents remains limited to very few people. There is no opportunity to see where the "boss" really stands on the topic, how these cases are handled, or how safe it is to come forward. Contrast that with a recent airline accident when the president of Swissair, within hours of a fatal crash, discussed the fact that his airline is excellent, but not perfect. He said it was a terrible tragedy for which he needed to take responsibility, deal appropriately with the families, pursue the facts, and learn from it. Swissair obviously could not hide from the accident and he, the airline's most senior leader, did not.

> **'Everyone knows that errors, slips, and near-misses occur routinely in health care organizations—it's no secret. Yet few know how often they happen, what their outcomes are, or what is being done to prevent recurrence.'**

Boston's Dana-Farber Cancer Institute enjoys a partnership with its Patient and Family Advisory Committee. A few years ago, the patient co-chairs of the committee attended their first of what are now monthly meetings of the adult care quality improvement committee. Aggregate information was presented on medical errors, near-misses, slips and falls, and other incident data. At the end of the meeting, the patients were asked if they were overwhelmed by what they heard. Their response was an impressive jolt of reality: "We are cancer patients and we know all of these things happen. We just didn't know you knew or that you were all trying as hard as you are to fix these issues." The staff of the Institute was left wondering who is kidding whom around patient safety.

Health care, much like Swissair, is excellent but not perfect. Everyone knows that errors, slips, and near-misses occur routinely in health care organizations—it's no secret.

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## A CEO Calls for Leadership

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***Jim Conway,*** *a diplomate in the American College of Healthcare Executives, is the Chief Operations Officer of the Dana-Farber Cancer Institute, Boston, a Board Member of the National Patient Safety Foundation, and a steering committee member of the Massachusetts Coalition for the Prevention of Medical Error.*

Yet few know how often they happen, what their outcomes are, or what is being done to prevent recurrence. Health care executives must acknowledge the reality and see their role in it, preside over visible forums to talk about safety, implement plans to reduce error, and establish the appropriate culture to support reporting, accountability, responsibility, and improvement. Are there risks? Sure! There could be a lawsuit, uncomfortable public scrutiny, bad press, and board and community attention—but there is a lot leaders can do and say without incurring significantly greater risk.

Health care leaders can send a strong message emphasizing their understanding of the realities of practice and applying their personal leadership to improve patient safety. Growing numbers of institutions have dealt very openly with patient safety issues and now have even stronger ties to their patient, staff, and external communities.

**What do staff members want from leadership?**
Even if health care leaders consider themselves enlightened, it is unusual to have groups clamoring for their help and participation. What does staff want from leadership? First, they want to see their leaders open an umbrella of safety, security, and support that makes it OK to stick your head out, ask questions, and talk honestly about and learn from what is going on. Staff members need to hear a strong leadership vision and see strong participation that will consistently guide and support them through a very rocky time of dramatic culture change.

There's no question; for everyone in health care, this is a scary time with considerable conflict. They didn't teach this kind of openness in school; this isn't the way physicians were taught to practice, and health care peers, patients and families, professional associations and boards have different levels of understanding of the challenges ahead. These are very choppy waters and staff needs the engagement of strong leadership to help them move forward. This must also include leaders' willingness to stick their neck out for their staff.

Staff will also want education in this new culture. All health care leaders have experienced some dramatic change, sought out the rules in the new entity, and worked hard positioning themselves to be successful. Leaders play an enormous role in making training available and in helping people position for success.

The positive results of leadership engagement are being seen in institutions and through initiatives such as the Massachusetts Coalition for the Prevention of Medical Errors and the National Patient Safety Foundation. It is essential that all leadership respond to this now. Patients, their family members and health care staff deserve no less. **NPSF**

### A Word from Outgoing Managing Editor Lorri Zipperer

From its inception, *Focus on Patient Safety* has looked to bring the multidisciplinary issues that impact patient safety to the fore. That it has done, I believe, during my tenure as managing editor.

As I pass on this responsibility while continuing with others, I would be remiss to not thank the individuals and NPSF board and staff who have contributed their time to this cause. The newsletter wouldn't have happened without the energy of our authors. Their willingness to contribute to the literature of the patient safety community helped to keep *Focus* vital and provocative.

The torch will be passed on to Dawn McGinley, NPSF Director of Communications, in whose capable hands this publication will continue to inspire and inform those whose imagination and ingenuity will help make safer health care a reality.

Lorri Zipperer, MA
Managing Editor
Winter 1997—Summer 2000

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## Editor's Note:

It has been brought to our attention that an additional reference regarding the article "Keep the Nurse in the Workplace" in Volume 3:2 was inadvertently missed:

Knox GE, Kelley M, Simpson KR, Carrier L, Berry D. Downsizing, reengineering and patient safety: Numbers, newness and resultant risk. *J Healthcare Risk Manage.* 1999;19(Fall):18-25.

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# Using the Power of Computers to Prevent Medical Errors

BY JAMES BURGESS

*James Burgess* is general manager of 3M Health Information Systems, a leading developer of computer-based patient record systems.

For more information, call 1-800-367-2447 or visit www.3mhis.com

Last November, some frightening statistics were revealed to government officials, the media and the public. The Institute of Medicine (IOM) reported that tens of thousands of patients die every year as a result of medical mistakes after they are admitted to US hospitals. Even more patients are injured to some degree by the treatment they receive in hospitals.

The 1999 report by the IOM, an organization operating under the National Academy of Sciences, said that half of these fatalities and injuries could be prevented by rectifying defective systems that clearly do not spotlight errors in treatment, before they kill or injure.

Fatality- and injury-producing errors, according to the report, do not happen because of "individual recklessness." They more often originate in the health care system's inherent disorganization, archaic practices, and rapid growth. For example, several practitioners may treat the same patient, but not have a thorough picture of what their colleagues are doing. Or patients with serious conditions may receive many powerful drugs simultaneously that in combination have the potential to do harm. According to the IOM report, medication errors alone account for 7,000 deaths annually.

Integrated health care delivery systems cannot deliver first-class care—and prevent medical errors—unless clinicians have easy access to all patient clinical data at all settings. A significant amount of clinicians' time is wasted just in trying to locate information—from missing paper charts to x-rays lost in transit to delayed reporting of lab test results. Delays in communicating critical medical information can result in complications, necessitate additional procedures or medications and increase a patient's length of stay. Meanwhile, the patient's comfort and safety may deteriorate.

**Using technology to improve efficiency and effectiveness**

The IOM report stresses the need for systems designed to prevent, detect and minimize hazards and the likelihood of error. The good news is that such systems are available today. In fact, a number of organizations are successfully using advanced information technology to develop the necessary foundation for sophisticated monitoring of patient treatment. How is such a foundation created?

By bringing integrated patient data from many sources and existing systems into a central database of individual life-time patient records for access and clinical analysis.

**'Integrated health care delivery systems cannot deliver first-class care—and prevent medical errors—unless clinicians have easy access to all patient clinical data at all settings.'**

These computer-based patient record (CPR) systems are providing clinicians with decision-support tools available at the point of care—where and when they can make a difference in both outcomes and cost. By delivering the right information to the right people, immediately in real-time, a comprehensive CPR system can save time and facilitate crucial care decisions. Instead of searching for paper charts, reports, and records, clinicians and administrators can access automated features that:

* Continually monitor new patient data from facilities throughout the enterprise;
* Compare the data instantly with historical data; and
* Automatically send alert messages to appropriate users when dangerous or questionable situations arise.

Having patient data instantly online allows physicians to provide more effective and efficient care across the care continuum. They can track chronic illnesses, monitor possible drug interactions, and review lab results in a timely manner. Better patient information means less unnecessary treatment, lower care costs, better outcomes, and improved patient safety.

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# Safe Practices Make Safe Patients

BY LISA H. SCHECK, MSJ

Hippocrates said it most concisely: "Thou shalt do no harm." The ancient Greek physician's oath stands as the origin of patient safety today.

Adhering to his philosophy, medical practitioners should cause no harm either by errors of omission or commission, said health care attorney Ellen E. Stewart, JD, MSHA, FHFMA, Gorsuch Kirgis, Denver. She addressed the topic of patient safety during "Keeping Our Patients Safe," an audioconference presented by the Medical Group Management Association (MGMA) Center for Education.

Based on this view, Stewart focused on three areas of patient safety—problems related to misuse, overuse and underuse, and omission of services. "The key to patient safety is a recognition that accidents will happen, and patients can be harmed as a result," she said. "When an accident or 'near miss' occurs, the question to be asked is not *who* but *why* the situation occurred and *how* the medical group can change the way things are done to keep the situation from happening in the future."

Stewart reviewed 10 points in the ambulatory visit that can pose hazards for patients, and that a practice's awareness can eliminate or mitigate.

**1. Calling for the appointment**
A practice should address patient safety even before the patient steps into the office. Use the initial phone call to screen for potential issues. Does the patient have special needs, such as transportation, supplemental oxygen, respiration equipment or other extra assistance? Ask about the need for continuity of care from previous providers. For instance, can the patient or previous providers supply copies of relevant records, X-rays or tests? Are there any environmental hazards, such as wearing certain scents around an allergic patient? This type of situation could be alleviated with a blanket policy at an allergy practice, rather than on an ad-hoc basis by forbidding employees from wearing perfume or aftershave at work.

**2. Arriving at the practice**
Physical barriers may pose hazards when patients arrive at the physician's office, Stewart said, such as snow on the parking lot and/or sidewalks, parking at a distance from the office building, stairs, wet floors and poor lighting. Seniors at particular risk fall under such circumstances.

"I focus on the elderly because they often have problems with eyesight and can be unsteady on their feet," Stewart said. The Americans With Disabilities Act (ADA) mandates businesses to provide access for physically impaired individuals. Make sure your practice is in compliance with ADA regulations regarding building access and safety, Stewart advised. She recommended conducting an assessment of the property including a review of the lease for building maintenance; arrangements for adequate parking, especially handicapped spaces; and adequate lighting in places such as parking lots, stairwells and lobbies.

If your practice owns the building, review safety procedures with the janitorial staff, she said, and don't forget security measures. Depending on the neighborhood, patient safety may call for measures such as a security guard in the parking lot or lobby, and/or a buzzer admission system at the door, especially if patients arrive at or leave the practice after dark.

**3. The reception desk**
This area focuses on patients' presenting conditions, directions given by your staff and patient confidentiality. It's essential to train your staff to assess patients arriving at the reception desk. Is the patient unusually short of breath, sweating profusely, incoherent or disoriented? These can be signs of serious physical problems that need immediate medical attention. In an emergency, "Treat first and ask questions later," Stewart urged.

To assess the clarity of directions given to arriving patients, Stewart suggested using a mock-patient—a person who has never been in the practice—for a walk-through of the clinic. Find out if the person understands directional signs and instructions on where to go and what to do. Discover if any language or translation barriers exist among staff members who interact with patients. Hearing- and sight-impaired patients also have special needs.

Patient safety embraces patient confidentiality. Stewart pointed out that the reception desk can offer multiple opportunities to breach patient privacy, such as:

- Patients being able to view computer monitors displaying patient information;
- Sign-in sheets that allow registering patients to read the names of other scheduled patients; and

- Patient charts sitting on the counter for anyone to leaf through.

Although the Health Insurance Portability and Accountability Act does not address all of these confidentiality hazards, it may soon include them, Stewart said. She advised practices to put procedures in place to anticipate all of these situations.

**4. The exam room**

Stewart's safety checklist for the exam room—a potential danger zone—urges practices to consider whether:

- A patient can be left alone due to his or her health condition or known substance-abuse problems. If this is a concern, put away prescription pads or controlled substances;
- Drugs and "sharps" are accessible;
- Your practice has a procedure for disposal of biohazards;
- You have emergency equipment consistent with the risk level of patients you deal with—such as automated external defibrillators in a cardiac or geriatric practice—and if the equipment is regularly maintained;
- You have a system to identify, minimize and eliminate patient hazards, such as blood-borne pathogens;
- You have a call system for patients to use in case of emergency;
- The temperature is comfortable in exam rooms;
- The practice has followed ADA guidelines for exam rooms and other patient facilities; and
- Sick employees are discouraged from coming to work and putting fragile patients at risk.

**5. Physicians reviewing charts**

At this point in the visit, Stewart urges medical practices to ask, "Does the physician have all the information needed to keep this patient safe?" Staff members need to know about any managed care restrictions that apply to the patient, such as "gag clauses," non-covered services and experimental services. Prior records on the patient should be available to the physician. Before the visit, staff should communicate to the physician any special considerations, such as missing information or concerns about the patient's behavior.

"[Having] the right records with the right patient at the right time is critical," Stewart said, noting that safety is an integral part of corporate compliance regulations for medical practices. "Your patient safety program should fit wonderfully well with your corporate compliance program, and it is an integral part of your risk management program."

**6. Physicians examining, conducting tests**

Stewart noted that attention to this area of patient safety could, in the long run, reduce a practice's insurance and malpractice premiums. Ensure that equipment is safe, that physicians are updated on current medical issues and, if non-physician providers see patients, that they have adequate training, licensing and continuing education (CME).

A proactive practice conducts its own internal auditing, Stewart said, to develop policies and mechanisms for equipment safety, monitor physician CME and practice competencies, measure process and outcomes according to quality performance indicators, and incorporate patient safety considerations into performance evaluations for physicians and staff.

**7. Patient referral for further testing**

Patient safety extends to referrals for testing. Can patients get to the testing location conveniently? Do patients understand why the tests are necessary?

The medical group's discharge summary should contain the following information: follow-up testing and results reporting, including procedures to assure subsequent action on abnormal test results; clear instructions for when and where to obtain the tests; and where, when and how to get the test results. Make sure patients receive this information both verbally and in written form. Stewart cautioned that written information should appear in a type size large enough for seniors to read easily.

**7. Patients receiving a prescription**

When assessing patient safety regarding prescriptions, Stewart recommended that a practice:

- Identify prescriptions from other treating physicians;
- Ensure that the patient fills the prescription;
- Identify the amount and types of the patient's existing medications;
- Check for possible drug interactions; and
- Check for narcotic use, such as prescriptions filled by pain management centers instead of by the primary care physician.

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**'[Having] the right records with the right patient at the right time is critical.'**

*—Ellen E. Stewart, JD, MSHA, FHFMA*
*Gorsuch Kirgis, Denver*

***Lisa H. Schneck, MSJ,*** *is a senior editor at the Medical Group Management Association (MGMA), Englewood, Colorado.*

*For a brochure on the MGMA Center for Education's program on patient safety ("Keeping Patients Safe While Managing Your Risk"), June 1 in Chicago, call the MGMA fax-on-demand service toll-free at (877) FAX-MGMA (329-6462) and request Document #1046.*

## Safe Practices

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**8. Patients should be told to call if things get worse**
Stewart said to identify where patients should go if problems arise—office, emergency room or primary care physician. Tell patients their options for phone calls, such as the practice's on-call physician or an after-hours call center. Review the office mandate for follow-up on physician instructions, and assess the practice's compliance with its own policies and procedures, she advised.

**9. Patients leaving the facility**
A patient's departure from the office can be fraught with risk. "This is a big issue, especially if you've done something to the patient," Stewart said.

For example, a patient leaving an ophthalmologist's office with dilated pupils may present a driving risk unless provided with dark glasses. Driving would be dangerous, as well, for emotionally distraught patients. Patients on medication, at risk for seizures, or impaired by alcohol or substance abuse also should not get behind the wheel, Stewart said.

She advised practices to identify protocols for patients leaving against medical advice, for notifying law enforcement if an at-risk patient insists on driving and for staff assessment of patient capabilities to leave the office.

Stewart said accidents will happen, and when they do, try to learn from them.

- Use the opportunity to assess things within your practice, she advised. Conduct a root-cause analysis and decide if system changes are needed. Ask whether polices and procedures have been adequately documented and reviewed with staff—and if those rules were followed in this instance. Ask if your practice meets Occupational Safety and Health Administration requirements. If you're part of a managed care organization, it may have safety rules to review.

"Many managed care companies have not thought about patient safety, but they're beginning to," Stewart said, "and that will mean more standards to uphold. Practices should not regard patient safety as an onerous burden; instead, it's practical and humane," she concluded. **NPSF**

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## Call for Abstracts

CONTINUED FROM BACK COVER

**Who can submit abstracts?**
Everyone, including purchasers, risk managers, patients/consumers, clinician educators, clinicians, consultants, patient advocates, as well as representatives of the legal community, health systems, manufacturers of medical products and standards-setting organizations.

**What are the criteria for abstracts?**
Eligible programs must be:
1. Tested, implemented and proven to reduce errors and/or improve patient safety;
2. Scientifically based;
3. Practical to implement and administer;
4. Creative and innovative; and
5. Transferable across organizations and settings.

Abstracts should not exceed three pages and must include a summary of the proposed presentation with bibliography, as well as a resume or biographical sketch of up to 100 words.

**Authors should consider the following topics:**
- Solutions that have overcome barriers to error reporting, diagnosis and disclosure.
- Ways to measure errors that lead to better understanding of the causes and failure indicators for error.
- Clinical solutions—ways to reduce errors in anesthesia, diagnostics, surgery, medication dispensing, etc.
- Systems error reduction—
  a. Ways leadership can foster environments that support error disclosure and ameliorate internal cultural obstacles that may impede safer health care practices.
  b. Human factors, risk management and other strategies that have improved patient safety.
- Technical solutions—Innovations in the product development sector that assist systems and clinicians in measurably reducing the incidence of error, avoidable patient injury and associated costs.
- Educational solutions—"Systems learning" approaches that encourage deepening understanding of error, responsibility and the dynamic interaction between human, technological and organizational factors in high-risk settings.
- Cultural solutions—
  a. Patient empowerment programs and productive patient/clinician partnership approaches to prevent harm.
  b. Innovation in developing values systems, incentive alignment, consumer outreach activities, and communication and information feedback programs.
- Environmental solutions—
  a. Ways to modify the legal environment, which currently emphasizes fault and punishment.

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## Power of Computers

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**Enhancing treatment**

Computer-based patient records combined with decision-support software can have an enormous impact on the quality of patient care, as demonstrated by a number of research studies conducted over the past decade:

- Physicians who were reminded by automated systems to give flu shots to target populations vaccinated eligible patients twice as often. There was a documented morbidity decrease of 10 to 30 percent among vaccinated patients.[1]

- In an 18-month survey of 37,000 patients at LDS Hospital in Salt Lake City, only nine verified adverse drug events (ADEs) were reported by traditional detection methods. In the same period, 731 verified ADEs were detected solely by the hospital computer's expert system. Previous to the study period, a total of 10 to 20 verified ADEs were reported per year. Detecting and tracking ADEs is essential to solving the process problems that caused them.[2]

- Brigham and Women's Hospital in Boston has implemented seven "panic" laboratory value alerts as part of an automated alert system that pages the physician when a life-threatening laboratory value is detected. In a four-month period, physicians responded to 342 lab alert pages, and indicated they would "take action" as a result in 74% of those alerts.[3]

- Physicians at Boston's Beth Israel Hospital responded on average 21.1 hours sooner when they received system alerts on rising creatinine levels in inpatients on nephrotoxic drugs.[4]

**A commitment to better patient care**

The IOM report contends that medical mistakes are not caused by bad people. Instead, good people are working in health care environments with outdated and inefficient processes that need to be made safer. The report concludes that the know-how exists to prevent many medical mistakes and sets a minimum goal of a 50 percent reduction in errors over the next five years. A growing number of health care organizations are well on their way to achieving this goal by allowing clinicians to incorporate the power of computers into the processes of care. **NPSF**

> **'[M]edical mistakes are not caused by bad people. Instead, good people are working in health care environments with outdated and inefficient processes that need to be made safer.'**

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ABSTRACTS—CONTINUED FROM PAGE 6

b. Alternative ways of resolving claims of patient injury.
c. Innovative use of legal or alternative dispute mechanisms to promote accountability and prevent patient injury.
d. Ways the media have advanced patient rights and drawn attention to patient safety.
e. Strategies used by accrediting and regulatory agencies to maintain standards for measurement and accountability, while fostering an external environment that stimulates disclosure of information about risk and error.

- Patient-provider communication solutions—
  a. Demonstrated strategy and results to improve care delivery and patient satisfaction through enhanced patient-physician communication.
  b. Effective and appropriate intervention programs for health care providers at risk.

**Submit your abstracts to:**

Mitch Dvorak, Program Manager, National Patient Safety Foundation, 515 N. State Street, Chicago, IL  60610. E-mail: mitch_dvorak@ama-assn.org. Phone: (312) 464-5418. Authors are encouraged to submit abstracts by e-mail, or provide six copies if submitted by mail. The deadline for abstracts is July 1, 2000. Authors of selected manuscripts will be notified by August 4; full papers are due September 1.

**For more information, visit www.ama-assn.org.**

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## Note New Chicago Conference Dates: October 4-6, 2000

*Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF) at the AMA, in Chicago, IL. The NPSF represents an unprecedented initiative to improve health care safety by studying why errors in the health care system occur and implementing safeguards to prevent such failures from injuring patients. NPSF board members represent every major segment of the health care system, as well as employers, medical ethicists, public health advocates and distinguished scientific research institutions.*

*The opinions expressed in this publication are not necessarily those of the National Patient Safety Foundation or of its board of directors.*

*To submit articles to, or publications for possible review in, Focus, please direct materials to: Dawn McGinley, Focus on Patient Safety, National Patient Safety Foundation at the AMA, 515 N. State Street, Chicago, Illinois 60610. Materials, inquiries and subscription requests for the publication will be accepted electronically at npsf@ama-assn.org or via fax at 312-464-4154.*

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# Call for Abstracts: Patient Safety Initiative 2000

## Spotlighting Strategies, Sharing Solutions

Has your organization developed safety solutions that work? Share your knowledge and be recognized! The NPSF and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are seeking abstracts outlining activities shown to reduce medical errors and improve patient safety.

*Solutions: Healthcare Strategies That Work* is a multi-faceted initiative to identify and disseminate proven, practical patient safety solutions. The initiative includes a call for abstracts, a compendium of published solutions, presentations at a Patient Safety Initiative 2000 Conference October 6 in Chicago, and newly announced NPSF Patient Safety Awards.

**Submit your abstracts by July 1**

Authors of abstracts that meet specific evaluation criteria (see page 6) will be invited to submit full papers. The NPSF and JCAHO will also invite selected authors to present their papers at the October Patient Safety Conference in Chicago.

**Wanted: Abstracts from all areas of health care**

NPSF and JCAHO are seeking abstracts on the following topics:

- Error reporting and disclosure
- Clinical solutions
- Systems error reduction
- Technical solutions
- Educational solutions
- Cultural solutions
- Environmental solutions
- Patient-provider communication solutions

**New conference dates: October 4-6, 2000**

Please note the new conference dates and venue. *The Patient Safety Initiative 2000: Spotlighting Strategies, Sharing Solutions* will be held during the Joint Commission Resources' October 4-6 National Conference on Quality and Safety in Health Care at Chicago's Palmer House Hilton. The Patient Safety Initiative will be held on Friday, October 6.

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