

# focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

## Leadership Walk-Arounds Develop a Culture of Safety In Ambulatory Care Settings

BY VICKIE STUCKEY, RN, MSN, PATIENT SAFETY COORDINATOR, THE MEDICAL CENTER OF CENTRAL GEORGIA

### IN THIS ISSUE

Leadership Walk-Arounds Develop a Culture of Safety in Ambulatory Care Settings

How Literacy and Communication Initiatives Improve Patient Safety

Stopping the Line: Implementing a Patient Safety Alert System

Patient Safety Leadership Fellowship Learnings Help Put Theory into Practice

Plan to Attend "Leadership from the Bedside to the Boardroom"

The Institute of Medicine's landmark report, *To Err is Human: Building a Safer Health System*,<sup>1</sup> estimated that 44,000 to 98,000 hospital patients die each year from medical errors. These inpatient numbers suggest the possibility of an even greater patient safety problem in the less-monitored ambulatory care arena.

More than 77% of all medical procedures are performed in ambulatory settings, yet there is scarce research dedicated to outpatient safety issues. Considering the large numbers and variety of healthcare personnel in the ambulatory setting and the numerous "handoffs" of responsibility, there is an obvious increased risk for error<sup>2</sup>—and need to address outpatient safety.

### Patient safety begins with leadership

Healthcare leaders can have a profound effect on their organizations' culture by demonstrating concern about patient safety. Although "culture" generally refers to a group's behavior and attitudes, group leaders can influence the environment in which those attitudes develop and flourish. Recognizing this strong influence, top leadership must use every available channel to continually communicate the importance of safety and focus on improvement.<sup>3</sup>

One way leaders can convey the patient safety message to staff is through Leadership Walk-Arounds. Incorporating these walk-arounds into the infrastructure of ambulatory care could be time well spent in developing a culture of safety in this growing area of health care.

When near-misses occur, healthcare workers are often reluctant to document them through an official form; as a result, patient safety issues often go unreported. Healthcare leaders need to know if something is going on in their organization that could lead to patient harm.<sup>4</sup> By circulating among the staff, leaders can encourage reporting and discussion of patient safety issues that otherwise would go unreported—and thus unnoticed.

### MCCG leaders "make the rounds" for patient safety

To help its leaders create a culture of safety, the Medical Center of Central Georgia (MCCG) implemented Patient Safety Rounds in November 2003. Since that time, the importance of the rounds has grown as leaders observe a culture change in staff and see how comfortable staff have become with the questions and discussion during the rounds. Rounds have recently been expanded into MCCG's ambulatory sites, including home health, hospice, home infusion, home medical equipment, 2 ambulatory health centers, and 3 urgent care centers.

---

**"By circulating among the staff, leaders can encourage reporting and discussion of patient safety issues that otherwise would go unreported—and thus unnoticed."**

---

### Project began with inpatient rounds

MCCG's Patient Safety Rounds project started with weekly inpatient rounds conducted by the chief nursing officer (CNO) and the patient safety coordinator. At the recommendation of the CNO, the vice presidents of these areas later began to visit their staff on a rotating basis. The CNO and vice presidents are strongly dedicated to making their rounds, letting only emergent issues stand in the way of the preset dates.

Leaders visit nursing units and patient care areas unannounced on a rotating basis. Their questions to staff are outlined in a template, but managers are encouraged to ask the questions in their own words. Leaders strive to have their conversations with staff be open, relaxed, and non-threatening. After the

CONTINUED ON PAGE 2

Vickie Stuckey, RN, MSN, is the patient safety coordinator in the accreditation department at the Medical Center of Central Georgia in Macon, Georgia. Contact her at 478-633-2084 or [stuckey.vickie@mccg.org](mailto:stuckey.vickie@mccg.org).

## References

- 1 Kohn L, Corrigan J, Donaldson M, eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press; 2000.
- 2 Frankel A, Simmonds T, Vega K. *Achieving Safe and Reliable Healthcare: Strategies and Solutions*. Chicago: ACE Management Series. Health Administration Press; 2004.
- 3 Hammons T, Piland N, Small S, Hatlie M, Burstin H. Conference synthesis: An agenda for research in ambulatory patient safety. Bethesda, Md: Agency for Healthcare Quality and Research; 2001. Available at: <http://www.ahrq.gov/about/cpcr/ptsafety/> Accessed July 12, 2005.
- 4 Patient Safety Essentials for Healthcare. Oakbrook Terrace, Ill: Joint Commission Resources; 2003.

Patient Safety Rounds, staff are encouraged to share their experience with their peers at unit staff meetings.

### Gaining staff trust takes time

Little information was elicited from staff in the early days of the rounds. When asked, "During the past few weeks, has anything happened on your unit that delayed treatment or caused patient harm?" staff were suspicious that the CNO was "fishing" for something that Risk Management had reported, or something leadership was investigating.

When asked "What on this unit do you fear may be the next thing that may cause harm to a patient?" or "What worries you when you go home that you fear may cause harm to a patient if we don't do something?" few staff were willing to express even the smallest concern. But as staff became more comfortable and word traveled about the Patient Safety Rounds, they became more open to talking about these issues. Now, the leader and patient safety coordinator often leave their weekly rounds with a list of staff concerns.

### Important: Follow up on staff concerns

Issues brought up by staff are often simple and can be corrected with a phone call or memo to a department. Complex matters require a more structured approach. These steps provide the structure for investigating staff concerns:

- Obtain information about the concern;
- Identify potential or actual bad outcomes resulting from the event;
- Analyze the information obtained;
- Identify every contributing factor, action, procedure, or cultural norm supporting—or failing to interdict—this perceived system weakness;
- Determine actions necessary to correct all of the above factors;
- Identify an "executive sponsor"—a leader with the authority to manage the actions;
- Assign responsibility for the actions;
- Follow up on the actions and identify what changes need to be made; and
- Provide feedback to the staff who contributed the information, letting them know what actions occurred as a result of their willingness to share their concern.<sup>2</sup>

The importance of providing feedback to the staff cannot be overemphasized. Without this feedback or letting staff see that something was done about their concerns, they will quickly let others know that leadership's concern about

patient safety is merely "lip service." It is crucial that staff receive timely follow-up communication and are notified of what the organization plans to do to address their concerns.

### Moving Patient Safety Rounds into the ambulatory environment

As the positive aspects of MCCG's leadership rounds were discussed in administrative meetings and other venues, ambulatory areas asked to be placed in the rotation. The leaders could find no literature or information on patient safety rounds in the ambulatory setting, so they decided to simply reword the Patient Safety Rounds questions for the outpatient/ambulatory environment and try to transform rounds for a different setting. This approach is proving successful as the question format has stimulated discussion with the staff on patient safety issues.

The vice president in charge of MCCG's ambulatory areas conducts rounds with the patient safety coordinator, giving staff an opportunity to voice their concerns. Initially, ambulatory care Patient Safety Rounds felt much like the early days of rounds in the inpatient setting: staff were suspicious as to what the leaders were really looking for, thinking they were asking questions to gather information about an actual occurrence. But as with the inpatient staff, the ambulatory care staff are becoming more comfortable with the questioning process each time they participate in Patient Safety Rounds.

Recently, some questions have been added in an effort to evaluate the staff's ideas about MCCG's medication reconciliation process. Conversation brought out home health staff's concern over the increased possibility for error when patients misplace their discharge instruction sheet listing their home medications. When this occurs, home health nurses are forced to rely on the patient's memory or make a list of medications from the prescription bottles the patient has on hand. Leadership's knowledge of staff's concern about home medications prompted the formation of a team of inpatient and home health nurses who are developing a safer process to reduce the chance of error.

### Patient safety: An evolutionary process

Laying the foundation for a culture of safety takes time and repetition. Ambulatory leaders should be unrelenting in communicating the importance of patient safety to staff and building on the success of Leadership Walk-Arounds in the inpatient environment. Adapting these rounds to the outpatient setting can help bring patient safety issues to the forefront; it is then up to ambulatory care leaders to promptly acknowledge and address these concerns to foster a culture of safety. [NPSF](http://www.npsf.org)

# How Literacy and Communication Initiatives Improve Patient Safety

BY JOSIE R. WILLIAMS, MD, MMM, DIRECTOR, RURAL AND COMMUNITY HEALTH INSTITUTE, THE TEXAS A&M UNIVERSITY SYSTEM, HEALTH SCIENCE CENTER

*“Communication, essential for the effective delivery of health care, is perhaps one of the most powerful tools in a clinician’s arsenal. Unfortunately, there is often a mismatch between a clinician’s level of communication and a patient’s level of comprehension.”*

—Barry D. Weiss, MD

## How much of what physicians say do patients understand?

Communication is identified as a primary root cause of patient error by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).<sup>2</sup> The Institute of Medicine’s *Health Literacy: A Prescription to End Confusion*, the American Medical Association’s *Understanding Health Literacy* and *USDHHS Healthy People 2010*<sup>3,4,5</sup> dramatically define an emerging understanding of how present communication with patients may lead to poor physician-patient relationships and inadequate communication.

Healthcare professionals are often unaware when patients fail to understand information or instructions. However, the emerging literature suggests healthcare professionals can improve communication with patients and thus enhance their patients’ healthcare outcomes and satisfaction.

Barry D. Weiss, MD, describes evidence showing that patients “often misinterpret or misunderstand medical information given to them by clinicians.”<sup>1</sup> He cites health literacy problems as an issue with 50% of patients.<sup>6</sup> Others point to a link between patients’ level of health literacy and their understanding of key information about their illnesses.<sup>7</sup>

“[Lack of] health literacy—an individual’s ability to read, understand, and use healthcare information to make effective healthcare decisions and follow instructions for treatment<sup>7</sup>—is a key reason why patients do not understand what clinicians tell them,” says Weiss.<sup>1</sup>”

Communication difficulties can have serious consequences. Toni Cordell, a literacy advocate from Charlotte, NC, recalls her own experience stemming from a learning disability. “Years ago, as a married woman with 3 children, it became obvious to me that I needed to visit the gynecologist,” she says. “Something was not right. Following the exam, the doctor told me, ‘That will be an easy repair.’ So surgery was scheduled. “As I sat across the desk from the admissions clerk, paper after paper was pushed in front of me,” says Cordell.

“I know the system. If you want the surgery, you sign all the papers. So I did that. The simple repair was successful, and I am grateful.

---

**“[Lack of] health literacy ... is a key reason why patients do not understand what clinicians tell them.”**

---

“During my 6-week follow-up appointment, the nurse walked into the examining room and cheerfully asked, ‘How are you feeling since your hysterectomy?’

“Thinking to myself, ‘How stupid could I be?’ I concealed my shock and answered, ‘Fine.’ Although I really didn’t want to have any more children, I couldn’t stop thinking, ‘How did I allow them to take part of my body and I never realized it?’ It was my fault as I never asked questions.”<sup>8</sup>

## Physicians often don’t recognize health literacy problems

Darren DeWalt, MD, MPH, assistant professor of medicine at the University of North Carolina at Chapel Hill, shares a concern of other health literacy researchers: physicians are largely unaware that their communications with patients are often inadequate. He cites studies suggesting that patients with asthma and diabetes have better outcomes if they have effective health literacy skills.<sup>7</sup> Aging patients are particularly vulnerable if they have literacy issues.

DeWalt suggests that healthcare professionals may unwittingly pose significant risks for patients by presenting patient-education materials, healthcare disclosure documents, and other materials commonly relied on for good physician-patient relationships and participatory decision-making that are overly complex and not understood by the patient.<sup>8</sup>

Archie Willard of Eagle Grove, Iowa, who identifies himself as a severe dyslexic, has become a literacy advocate. “[I did] a fellowship with the National Institute for Literacy, which opened my eyes to how things work in adult literacy in our country,” he explains. “Then a group of adult learners got together and we formed a local organization of

*NPSF Board Member Josie R. Williams, MD, MMM, is RCHI director and assistant professor of internal medicine and family medicine at the Texas A&M University System, Health Science Center, Rural and Community Health Institute.*

*Dr. Williams moderated the plenary session, “Listening to the People: How Literacy and Communicating Initiatives Improve Patient Safety” at the 2005 NPSF Patient Safety Congress. She serves on the editorial board of NPSF’s Journal of Patient Safety. Contact her at: williams@tamhsc.edu.*

## References

- 1 Weiss BD, ed. *Health Literacy: A Manual for Clinicians*. Chicago; American Medical Association Foundation and American Medical Association; 2003:4. [book online: <http://www.ama-assn.org/ama1/pub/upload/m/m/367/healthlitclinicians.pdf>]
- 2 Performance Improvement: Tips and Strategies for Using the Communication Priority Focus Area to Improve Performance. *Oakbrook Terrace; The Joint Commission International Center on Patient Safety*: ND. Available at: <http://www.jcipatientsafety.org/show.asp?durki=9861&site=149&return=9808> Last accessed August 19, 2005.
- 3 Nielsen-Bohlman L, Panzer AM, Kindig DA, DeWalt D. *Health Literacy: A Prescription To End Confusion*. Washington DC: National Academies Press; 2004.
- 4 Schwartzberg JG. *Health Literacy: Help Your Patients Understand*. Chicago; American Medical Association; 2nd Pkg edition: 2003.

*References continued on page 4*

CONTINUED ON PAGE 4

# How Literacy and Communication Initiatives Improve Patient Safety

CONTINUED FROM PAGE 3

## References

Continued from page 3

- 5 US Department of Health and Human Services, *Health Communication*. In: *Healthy People 2010, 2nd edition*. Washington DC; US Government Printing Office: 2000.
- 6 Weiss BD. *Epidemiology of low health literacy*. In: Schwartzberg JG ed. *Understanding Health Literacy*. Chicago; AMA Press; 2005.
- 7 DeWalt DA. *Health literacy and health outcomes: overview of the literature*. In: Schwartzberg JG ed. *Understanding Health Literacy*. Chicago; AMA Press; 2005: 205-227.
- 8 Cordell T, DeWalt DA, Willard A. *Listening to the People: How Literacy and Communicating Initiatives Improve Patient Safety*. Presentation at: National Patient Safety Foundation Congress; May 6, 2005, Orlando, Florida.
- 9 Covey S. *The Seven Habits of Highly Effective People*. 15th ed. New York: Free Press; 2004.

people with literacy problems called New Readers of Iowa (NRI). Just meeting others and knowing others with literacy problems was helpful.”<sup>8</sup>

Willard talks about the shame and dread that patients with written-word difficulty face when they seek medical care. He also stresses that health literacy issues have little to do with intelligence, desire, or capacity but have everything to do with the ability of healthcare professionals and their patients to communicate clearly with one another.

---

**“[H]ealth literacy issues have little to do with intelligence, desire, or capacity but have everything to do with the ability of healthcare professionals and their patients to communicate clearly with one another.”**

---

“We [NRI] knew we needed to be able to better use the healthcare system,” Willard says. “None of us knew of any health professionals to invite, so we decided to teach each other how we could better navigate the health system by doing the little things that we know how to do.” The group organized a conference to enlarge their sphere of influence for the people they knew would benefit from not being fearful of asking questions and learning from each other.

Adult-literacy facilitator Mary Ann Abrams, MD, MPH, came to the literacy conference—a gesture of care and concern that has been fruitful. “She was very impressed with our group and asked some of us to come to a health literacy meeting that the Iowa Health System [IHS] was having,” says Willard. “Some of us were then asked to be on the patient safety team at IHS.

After working with IHS for a year, NRI decided to have another health literacy conference in 2004. “This time we partnered with IHS to put on the conference,” Willard explains. “They provided a panel of medical professionals who told us about how hard it is to give the best health

care when they don’t know we have literacy problems. They encouraged us to be open about our reading problems. We told them the problems we face going into a clinic as poor readers. We looked at IHS consent forms and told them what we could understand about the forms and what we didn’t understand. When we left the conference, we all went away with a better understanding of each other’s problems.” IHS and NRI are now planning their fourth conference together.

Willard and his NRI colleagues have learned “Ask Me 3”—a communication strategy based on a program from the Partnership for Clear Health Communications. Ask Me 3 teaches patients to ask their healthcare professional 3 basic questions: “What is wrong?” “What needs to be done about the problem?” and “Why is it important?” NRI has also worked on patient-friendly federal prescription legislation.<sup>8</sup>

“Every patient should be a full partner in medical decisions,” says Cordell. “This requires clear communication, with compassion and respect.” She then described what occurs when assumptions are made and communications are not clear.

“It seems different professions have their own vocabulary,” Cordell explains. “When my husband, Carl, was in the media, he covered Nelson Rockefeller’s vice presidential campaign visit to San Francisco in the 1960s. Carl and the TV cameraman found a spot to pull over to view the parade route. “When they got out of the car, Carl suggested that Bill “get out the shotgun and shoot from the top of the car.” The Secret Service agents understood that communication differently, and Carl and Bill were detained.

A *shotgun* is a long directional microphone that picks up sound from a limited area,” Cordell explained. “Carl and Bill’s intention was to shoot film of the event. But what was clear to them was *not* clear to the Secret Service.”<sup>8</sup>

In Steven Covey’s book, *The Seven Habits of Highly Effective People*, one of the habits is to “Understand before being understood.”<sup>9</sup> Communication is a crucial skill for all healthcare professionals—and there is much to learn from patients about what is effective. **NPSF**

**2006 Patient Safety Awareness Week  
March 5-11**

Our Patients—Our Partners  
One Team, One Goal  
Visit [www.npsf.org](http://www.npsf.org)

# Stopping the Line: Implementing a Patient Safety Alert System

BY CATHIE FURMAN, RN, MHA, VICE PRESIDENT OF QUALITY AND COMPLIANCE, VIRGINIA MASON MEDICAL CENTER, SEATTLE

In 2002, Virginia Mason Medical Center (VMMC) in Seattle, Wash, created the Virginia Mason Production System (VMPS) as its management method for delivering health care with ever-increasing safety, quality, and economy.

VMPS is the healthcare management version of the Toyota Production System. One of the most important management techniques in Toyota's system is "stopping the line"—each employee's responsibility to halt any activity that is generating a defective product.

## VMPS "stops the line" for patient safety issues

To translate the technique of stopping the line into health care, VMMC developed the Patient Safety Alert System and applied it to healthcare providers and clinical processes beginning in September 2002. The Patient Safety Alert System requires any employee who encounters a situation likely to produce patient harm to report it immediately to the Department of Patient Safety using a 24-hour hotline, and to cease any activity that could promote further harm.

When a report is received, an administrator or physician leader is immediately sent to the source of the problem to evaluate it and to initiate a focused review. This process is analogous to a code for cardiopulmonary arrest; a Patient Safety Alert (PSA) is a "code safety." If the problem cannot be understood and remedied immediately, a root cause analysis is performed. The healthcare process associated with the problem does not restart until a remedy is approved by the vice president of quality, the responsible executive of the involved department, and the CEO.

## VMPS receives a growing number of reports from staff

As of April 2005, VMMC's Department of Patient Safety has received over 611 reports: 20% from physicians; 30% initiated by nurses; and the remaining half from non-clinical support personnel. The number of reports per month has increased from an average of 3 in 2002 to 17 in 2004 to 66 in 2005 after the process was refined as described below.

The increase in reporting is viewed as a favorable trend and an indication that the organization is strengthening its commitment to a culture of safety. The average number of days to resolve an event has decreased from 18 in 2002 to 13 in 2005. Approximately half of the reported events involve complex or multidisciplinary aspects of patient

care; equipment failure accounts for approximately 20%; and medication errors and problems with professional conduct each account for approximately 10%.

---

**"The Patient Safety Alert System requires any employee who encounters a situation likely to produce patient harm to report it immediately ... using a 24-hour hotline, and to cease any activity that could promote further harm."**

---

Both processes and individuals can be taken "off line" until the investigation is complete. Examples of situations that have been stopped and then restarted after appropriate remedies include: inappropriate physician behavior toward staff; a medication error resulting in respiratory arrest; failure to provide a history and physical prior to surgery; a construction site failure resulting in an unsafe work site; and malfunction of a patient-transport elevator.

## VMPS system has reduced harm to patients

After the tragic death of a patient due to a mix-up of unlabeled solutions, VMMC implemented a VMPS concept known as *source inspection* which requires each staff member involved in a process to check the work of the person who last touched the process and to check their own work before handing off to the next person. Source inspection has identified errors in labeling of medications and solutions and prevented mix-ups from occurring.

## Continuous improvement: Refining the program

Originally, VMPS differentiated some reports as not meeting the program's "significance" criteria. Staff feedback indicated, however, that it was confusing and disconcerting when an issue they identified was not considered "significant" enough to be a PSA. Since including those reports, the average number of PSAs has increased to 66 per month. **NPSF**

*Cathie Furman, RN, MHA, is vice president of quality and compliance at Virginia Mason Medical Center in Seattle, Wash. Contact her at 206-223-6182 or [cathie.furman@vmmc.org](mailto:cathie.furman@vmmc.org).*

# Patient Safety Leadership Fellowship Learnings Help Put Theory into Practice

BY JULIE NUNES, RN, MS, CHPRM, DIRECTOR OF REGIONAL RISK MANAGEMENT, NORTHERN CALIFORNIA REGION, AND SHARON McFERRAN, RN, CPHQ, PhD, GROUP LEADER, NORTHERN CALIFORNIA REGIONAL RISK MANAGEMENT, KAISER PERMANENTE

The NPSF co-sponsored Patient Safety Leadership (PSL) Fellowship focuses on providing excellence in an educational experience for healthcare professionals. Noted thinkers in patient safety and experienced facilitative lecturers present leading-edge philosophies and techniques to the leadership fellows over a one-year period.

Kaiser Permanente's Northern California Region has used the learnings from the fellowship in its Perinatal Patient Safety Project (PPSP) and replicated these improvements throughout its region.

## Moving beyond blame and shame

A primary challenge in patient safety is to move away from using blame and shame in response to medical errors and focus instead on creating safer systems. This problem is exemplified in a *New York Times* article by Marc Santora on May 21, 2005,<sup>1</sup> headlined "Director Fired at Hospital After Botched Pap Test Results." Santora's article details how Jacobi Medical Center in Bronx, NY, fired many people because of "a flawed system." Although the article acknowledges that the error was due to a system problem, the medical center failed to recognize that firing the people would not change the system that produced the error.

The approach to medical error used by Jacobi Medical Center is not unusual in health care; however, nothing changes by using blame and shame. To help move beyond that approach, the Kaiser PPSP's goal was to create high-reliability perinatal units based on work by Karlene Roberts<sup>2,3</sup> as well as Eric Knox, MD, and Kathleen Rice Simpson, RN.<sup>4,5,6</sup>

The PSL Fellowship presented methods that moved away from punitive approaches and explored new ways of avoiding error and evaluating the systems that had produced the errors. Information was provided from industries such as aviation and the US Navy. The approaches focused on using:

- A multidisciplinary team;
- Human-factors approaches to improve communication—by far the major contributor to significant events;<sup>7</sup> and
- Systems improvements based on performance-enhancement models such as those espoused by W. Edwards Deming.<sup>8</sup>

## Field-testing new ways of avoiding error

With these principles in mind, Julie Nunes, RN, and Sharon McFerran, RN, developed and replicated PPSP. The project was

to be piloted in 4 medical centers; with its success, it was instituted at 4 additional sites in 2004 and 2005. The PSL Fellowship supported the project's approach, expanded understanding of the methods, and introduced new approaches for consideration.

The role of leadership in patient safety, says Susan Dover, PhD, MPH,<sup>9</sup> is "pretty important, but not as important as teamwork." It is within the team, made up of people at the 'sharp end'<sup>10</sup> of the system, that real system knowledge exists. Within the team lies joint accountability, or backing up one another in achieving intended care outcomes.<sup>11</sup>

In Kaiser's PPSP, each site developed a multidisciplinary team to help integrate the new human-factors approaches into the culture of their perinatal unit as well as to implement system changes. These teams consisted of: obstetricians; nurse midwives; perinatologists; neonatologists; pediatricians; registered nurses from labor and delivery (L&D), post-partum and the neonatal intensive care unit; unit assistants; anesthesiologists; certified nurse anesthetists; care partners; clinical nurse educators; and others.

## Developing a shared mental model

A 4-hour human-factors training was the first step in getting the multidisciplinary team members on the same page—to have a "shared mental model."<sup>12</sup>

The goals of human-factors training are to:

- Promote awareness and understanding of factors that shape human performance; and
- Develop team-based communication and interaction practices that limit error and flag hazards for analysis and correction.<sup>13</sup>

Human-factors training deals with the interpersonal skills implicated in adverse outcomes; it helps detect threats to patient safety, avoid errors and manage in a team-based environment. The training emphasizes the Human Factors Family of Skills, including: communication; briefings; monitoring and cross-checking; situational analysis and identifying red flags; and assertiveness. The training also addresses human limitations, such as: limited memory and mental-processing capacity; limits imposed by stressors; and those imposed by fatigue and physiological factors.

## Human-factors training proves essential for success

PPSP does not work without human-factors training. Without a shared vision of human factors, one team was

unable to function effectively and was closed down until training was completed. Their post-training work was highly effective. Based on this experience as well as the literature, human-factors training before the first team meeting became a requirement.

Human-factors training presented a method for structured communication borrowed from the US Navy's submarine service called SBAR (Situation, Background, Assessment, and Recommendation). This communication template was taught to everyone who worked in L&D. In addition, human-factors training taught assertiveness skills and that it is appropriate to put a patient's safety first.

#### Implementing a multidisciplinary approach to safety

To support better communication, PPSP introduced multidisciplinary rounds as well as briefings and debriefings. These multidisciplinary rounds, stemming from crew resource management (CRM) methods devised to engage all crew members in situation assessment and management,<sup>14</sup> shared the plan of care and addressed "What could go wrong?" concerns. Many times, these rounds ran counter to the existing culture of the participants.

The goal of the PPSP culture change was to achieve safe and reliable intended outcomes in knowledge-intensive systems. These systems rely on the ability of front-line personnel to engage in effective knowledge-based problem solving and action—or, more accurately, to blend and skillfully execute rule-based and knowledge-based responses to evolving situations.<sup>15</sup>

#### Providing emotional support for healthcare teams

It became apparent that there was a need to support the Kaiser physicians and staff after emotionally trying patient-care situations. In cooperation with the Employee Assistance Program (EAP), any team member could call a post-event debriefing facilitated by EAP to discuss the event. Additional support was provided by documents signed by the legal department and executive leadership giving permission to and specifying with whom an individual could discuss the details of the event as well as with whom an individual could discuss their feelings about an event.

These actions addressed 3 of the many interdependent categories that shape human performance: psychosocial, organizational, and behavioral.<sup>15</sup> This new approach to

supporting staff was communicated widely across the program. These measures are only a tip of the iceberg that correlates actions taken with lessons learned in the PSL Fellowship. Kaiser's PPSP has been a project, but it is not one on which the book can be closed because of another Fellowship learning: "Highly reliable organizations recognize that safeguards and countermeasures against failure must be continually assessed, and that decisions made at any managerial or administrative level may have the unintended effect of creating new hazards or error-provoking conditions. Further, they focus on supporting front-line units, not only to identify safety problems and monitor corrections for effect, but to drive continuous quality improvement."<sup>16</sup> **NPSF**

#### References:

- 1 Santora M. Hospital dismisses director over botched pap test reports. *New York Times*, May 21, 2005; Metropolitan Desk:5.
- 2 Roberts KH. Some characteristics of high reliability organizations. *Organ Sci.* 1990;1:160-177.
- 3 Roberts KH, Bea RG. Must accidents happen: lessons from high reliability organizations. *Acad of Manage Exec*, 2001;15:70-79.
- 4 Simpson KR, Knox GE. Perinatal teamwork: turning rhetoric into reality. In: *Perinatal Nursing*. Philadelphia. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and Lippincott, 2nd ed. 2001.
- 5 Simpson KR, Knox GE. High reliability perinatal units: an approach to the prevention of patient injury and medical malpractice claims. *J Healthc Risk Manag.* 1999 Spring;19(2):24-32.
- 6 Simpson KR, Knox GE. Adverse perinatal outcomes: recognizing, understanding and preventing common accidents. *AWHONN Lifelines*, 2003;7:224-235.
- 7 *Root Causes of Sentinel Events*. Oakbrook Terrace, Ill. Joint Commission on Accreditation of Healthcare Organizations. 2004. Available at: [www.jcaho.org](http://www.jcaho.org).
- 8 Deming WE. *The New Economics for Industry, Government, Education*. Massachusetts Institute of Technology, Cambridge, Mass; 1993.
- 9 Interview with Susan Dover. In: Brown JP, ed. *Patient Safety Leadership Fellowship 2004-2005, Module 4: Lessons from Inside and Outside Health Care*. Chicago: Health Forum; 2005.
- 10 Reason J. *Human Error*. Cambridge University Press, New York, NY: 1990.
- 11 Interview with Marilyn Sue Bogner. In: NPSF Fellowship 2004-2005, Module 4: *Lessons from Inside and Outside Health Care*, 1.
- 12 Brown JP, ed. *Patient Safety Leadership Fellowship 2004-2005, Module 4: Lessons from Inside and Outside Health Care*. Chicago: Health Forum; 2005. Overview, 4.
- 13 Brown JP. Structuring communication for team-based error management. *J Healthcare Risk Manage.* 2004;24(4):13-19.
- 14 Brown JP, ed. *Patient Safety Leadership Fellowship 2004-2005, Module 4: Lessons from Inside and Outside Health Care*. Chicago: Health Forum; 2005. Overview, 5.
- 15 Brown JP, ed. *Patient Safety Leadership Fellowship 2004-2005, Module 4: Lessons from Inside and Outside Health Care*. Chicago: Health Forum; 2005. Overview, 6.
- 16 Brown JP, ed. *Patient Safety Leadership Fellowship 2004-2005, Module 4: Lessons from Inside and Outside Health Care*. Chicago: Health Forum; 2005. Overview, 7.

*Julie Nunes, RN, MS, CHPRM, is director of regional risk management for Kaiser Permanente's Northern California Region, and the principal investigator in Kaiser's Perinatal Patient Safety Project. Nunes is a 2004-2005 PSL Fellow and a 2005-2006 IHI Fellow. Contact her at 510-987-4174 or Julie.Nunes@kp.org.*

*Sharon McFerran, RN, CPHQ, PhD, is a group leader, Northern California Regional Risk Management for Kaiser Permanente and serves as project manager for Kaiser's Perinatal Patient Safety Project and Medical-Surgical Patient Safety Project with Rapid Response Teams. McFerran is a 2004-2005 PSL Fellow. Contact her at 510-987-4324 or Sharon.V.Mcferran@kp.org.*

Focus on Patient Safety  
(ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in North Adams, Mass. 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 or publications for possible review in Focus, please direct materials to: Lorri Zipperer, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation, 1120 MASS MoCA Way, North Adams, MA 01247. Materials, inquiries, and subscription requests for the publication will be accepted electronically at [info@npsf.org](mailto:info@npsf.org) or via fax at (413) 663-8905.

**NPSF President:**  
Diane C. Pinakiewicz  
Managing Editor: Lorri Zipperer,  
Zipperer Project Management,  
Evanston, Ill  
Editor: Susan Raef, WordPower  
Communications, Inc., Chicago

**Editorial Board**

Paul A. Gluck, MD  
NPSF Board Member  
Associate Clinical Professor  
University of Miami  
School of Medicine

John J. Nance, JD  
NPSF Board Member  
ABC News Analyst

Diane C. Pinakiewicz, MBA  
NPSF President

© 2005 National Patient Safety Foundation. Permission to reprint portions of this publication for educational and not-for-profit purposes is granted subject to accompaniment by appropriate credit to the NPSF and Focus on Patient Safety. Commercial reproduction requires pre-approval. Some fees may apply.

## Plan to Attend “Leadership from the Bedside to the Boardroom”



NPSF has partnered with AIG Healthcare to present a series of regional conferences in 2006, “Leadership from the Bedside to the Boardroom.” The series will offer skills and tools for effectively moving your patient safety initiatives forward and will provide strategies for:

- Leadership and team-building;
- Integration of safety, quality and risk; and
- Effective management—up, down, and across your organization.

The sessions will be led by James B. Conway, MBA, MSC, CHE, NPSF Distinguished Advisor and Former Executive Vice President and COO, Dana Faber Cancer Institute, with a case presentation by Clarian Health Partners. Curriculum support will be provided by Fellows from the NPSF Patient Safety Leadership Fellowship Program.

The meeting content will be continued in a new track at Leadership Day during the May 2006 NPSF Patient Safety Congress in San Francisco.

National Patient Safety Foundation®  
1120 MASS MoCA Way  
North Adams, MA 01247

**Get more information**

For the latest details on how to register for the conference nearest you, e-mail NPSF at [info@npsf.org](mailto:info@npsf.org). Conferences are free for Stand Up for Patient Safety member hospitals and AIG Healthcare Professional Liability insureds.

### Coming in 2006 to a city near you

Dallas	Feb. 14
Orlando	Feb. 24
Chicago	Feb. 28
Nashville	March 8
Costa Mesa, Calif.	March 16
New York	March 30
Philadelphia	April 4
Seattle	May 19
Honolulu	Aug. 15

