focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Second of a 2-Part Series

"Miracle on the Hudson"—Key Safety Lessons for the Healthcare Industry

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US Airways Flight 1549 and its successful landing in New York's Hudson River by Captain Chesley Sullenberger and his team—without any loss of life—has been heralded as a miracle.[1] Part 1 of this 2-article series on Flight 1549, in last quarter's issue of Focus on Patient Safety*, discussed the role of consumers in safety.[2]*

What can healthcare providers learn from aviation safety?

Flight 1549 provides valuable lessons learned from aviation safety that may be applied to delivering safe patient care. The ability of Sullenberger and his team to safely land Flight 1549 in the face of overwhelming odds is a testament to the aviation industry's investment in training and teamwork and proves the value of those investments. Part 2 of this series examines lessons from Flight 1549 that the healthcare industry can apply in pursuing the elusive goal of patient safety.

Practice makes perfect

By the time US Airways Flight 1549 landed in the Hudson River following a bird strike on January 15, 2009, Sullenberger had logged a total of 19,663 flight hours. First Officer Jeffrey Skiles, who was in the cockpit with Sullenberger, had logged 15,643. The 3 flight attendants aboard Flight 1549 had an average of more than 30 years' airline experience, with the least-experienced of them having 26 years.[3] Flight 1549's crew had well in excess of the 10,000 hours of "practice" that some authors suggest are necessary to achieve world-class expertise.[4]

As with all flight crews, the pilots and flight attendants aboard Flight 1549 had practiced emergency landing procedures endlessly, and the pilots had practiced water landings in a flight simulator. This airline requirement enabled Flight 1549's crew to perform flawlessly when faced with a real emergency. Or, as Sullenberger put it during his televised interview with Katie Couric, "For 42 years, I've been making regular, small deposits in this bank of experience, education, and training. And on January 15, the balance was sufficient so that I could make a very large withdrawal."[5]

Measuring proficiency over time

How does the airline industry's ongoing training compare to that of health care? Simulation training is just starting to gain momentum in health care, but it is still not widely available to most clinicians. Although most healthcare disciplines do control entry into the profession through strict education, training, and licensing requirements, there is relatively little emphasis on ongoing training and demonstration of proficiency.

> "Flight 1549 provides valuable lessons learned from aviation safety that may be applied to delivering safe patient care."

Recredentialing of independent licensed providers is largely a paper exercise in examining reports and data on various aspects of practice. No attempt is made to verify competence through independent observation or performance in a simulator.

Continuing medical education requirements for physicians can be satisfied by attending didactic courses on a variety of topics, many of which may have nothing to do with the physician's area of practice. None of the healthcare professions requires its members to undergo regular drills to test their ability to perform under difficult circumstances or in emergencies. Responsibility to ensure ongoing competency in the healthcare professions is largely left to the individual, who can decide when, or if, he or she requires additional training or practice, and in which areas.

Only when there is a bad outcome, or a series of them, is the individual clinician's competency questioned or examined and additional or remedial training required. Thus, health-

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"Miracle on the Hudson"—Key Safety Lessons for the Healthcare Industry

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care professionals may not be able to make a "large withdrawal" from a knowledge fund established through years of incremental deposits, as did Sullenberger and his crew.

Teamwork is essential

The successful outcome of Flight 1549 would not have been possible without the training Sullenberger and his crew had in effective communication and teamwork. Flight 1549 was in the air for only 5 minutes before the water landing, and the bird strike occurred approximately one minute into the flight.

> "Health care has begun to realize that teamwork is critical to safety and that teamwork skills must be taught to healthcare professionals."

From that moment on, the plane's engines lost all power and the flight crew's response to the emergency had to be instantaneous and precise to ensure survival. It was. Why? Because the airlines know that precise communication is crucial to good performance, especially in emergencies when time is short. They also know from experience, and after listening to hundreds of cockpit voice recordings from flights that crashed, that teams function most effectively when roles are clearly identified and understood.

Airlines have learned that every member of the team—regardless of rank—needs to be empowered to participate in problem solving and to volunteer information that may be crucial to resolving the problem.

Cross-monitoring: An essential element of teamwork

The aviation industry has long understood that effective teamwork depends on "cross-monitoring." Each team member must be vigilant about the actions of other team members and offer corrective advice when problems are discovered, and be mutually accountable for the shared goal of the mission's safe conclusion. As a result, the aviation industry has for decades invested in "crew resource management" (CRM), a mandatory training program in these skills for flight crews.[6]

CRM training is what enabled the crew of Flight 1549 to respond instantly to the emergency without debating or clarifying anyone's role. They immediately assumed roles and responsibilities clearly defined in advance, coordinated their actions, and communicated without confusion or losing precious time.

CRM training allowed the crew of Flight 1549 to engage instantly in a coordinated problem-solving effort that saved the flight and all those on board, without wasting time or energy on interpersonal conflicts, egos, or fears of offending someone of higher authority while performing critical duties.

TeamSTEPPS models aviation's CRM program

Health care has begun to realize that teamwork is critical to safety and that teamwork skills must be taught to healthcare professionals. A communication and teamwork training curriculum based on the aviation industry's CRM program has been developed for healthcare organizations by the Agency for Healthcare Research and Quality. The program, known as "TeamSTEPPS," was first released in late 2007 and is available for free on the Internet.[7]

However, health care's adoption of the teamwork model is proceeding slowly. Progress is being hampered by adherence to traditional hierarchical authority structures that suppress rather than encourage input from healthcare team members, and by a lingering focus on punishment for errors.

Every healthcare team member's safety input should be heard

Research has shown that healthcare workers do not believe they are valued members of the team or that they are empowered to speak up if they perceive threats to safety.[8] There is a strong tendency among healthcare workers to keep quiet about colleagues' mistakes or judgment errors, even when patient safety may be at risk.[9] This is especially true when the individual to be questioned or challenged is of higher rank. Healthcare workers continue to perceive a punitive response to errors. Lack of respect among team members and disruptive behavior by some clinicians are also ongoing problems that undermine teamwork and put patient safety at risk.[10-12]

Standardized communication techniques such as SBAR (Situation-Background-Assessment-Recommendation), which can help to ensure precise exchange of information, are not used consistently or systematically. Adherence to procedural safety standards such as the universal protocol to prevent wrong-patient and wrong-site surgery is substantially less than 100%.[13] Individuals opt out of safety protocols at will and without apparent repercussions, aided and abetted by a culture that encourages team members to look the other way.

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New Simulation Program to Debut at 2010 NPSF Patient Safety Congress

Simulation-based techniques and their applications in healthcare will be a focus at the 2010 NPSF Annual Patient Safety Congress. The Learning and Solutions Center will offer a creative, dynamic transformation of the exhibit hall format featuring simulation experiences in a variety of healthcare settings. This approach will provide learning opportunities and solutions aligned with the theme and core content of the Congress.

In addition, 30 breakout sessions will offer depth and perspective on evidence-based applications and approaches to patient safety that have yielded measurable results and established a solid business case for this essential work.

Track topics include:

- Enhancing Process Reliability and Safety
- Implications of Health Reform for Patient Safety
- Harmonizing and Integrating Operational Practice with Policy and Regulatory Mandates
- Managing Complex Care across the Continuum
- Behaviors and Cultural Attributes that Drive Performance
- Managing Crowding and Overuse of Services: Implications for Patient Safety

NPSF will also feature interactive full-day Pre-Congress programs, motivational plenaries by influential healthcare leaders, and the popular Breakfast Roundtables. Details on the program, registration (including early-bird discounts), and hotel accommodations will be available in December 2009. For more information, visit *www.npsf.org*. NPSF

Call for Posters

NPSF invites abstracts for Research and Solutions posters to be presented at the 2010 Patient Safety Congress. Look for an announcement in late November 2009 at www.npsf.org.

"Miracle on the Hudson"

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Healthcare leaders need to invest in people

Flight 1549 and the aviation industry have much to teach health care about safety and the investments needed to improve both training and culture. This requires strong leadership commitment and difficult decisions to abandon old management models and forge a new culture of competence and teamwork. Improvements in patient safety will come not from investments in new buildings or equipment or advertising campaigns to increase market share, but from investments in people.[14]

The time has come for health care to invest in its workforce the way that aviation and other industries have done, and to create a team capable of doing what Capt Sullenberger and his team did—work efficiently, effectively, and successfully to keep the customer safe, and save lives when necessary. NPSF

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Using a Team Approach to Reduce the Risk of Contrast-Induced Nephropathy in the CT Suite

BY FRANCENE GLICK RT(R), DEBRA BARROW, PHARMD, MARINERS HOSPITAL, TAVERNIER, FLA

Computed tomography (CT) is a primary diagnostic tool that is quickly expanding from sophisticated hospital-based suites to outpatient centers, with the volume growing by millions each year. An estimated 66 million CT examinations will be performed in the United States in 2009 alone. Approximately 40% to 50% of these exams will be performed with systemic contrast administration for image enhancement, which is beneficial in some, but not all cases. Easy accessibility to what the medical community considers a safe and simple procedure has led to a sense of complacency.

Systemic contrast may put patients at risk of CIN

The widespread use of systemic contrast has had serious public health implications. Since the 1970s, contrast-induced nephropathy (CIN)—acute renal failure within 48 hours of exposure to systemic contrast and not attributable to other causes—has been recognized as a potentially fatal adverse drug event. Despite this, the need to identify patients at high risk of developing CIN is relatively ignored.

CIN: A potentially significant threat to patient safety

The significant growth of CT, coupled with the lack of a formal process to identify patients at high risk for CIN before administering systemic contrast, has potentially catastrophic results for patients. Of the estimated 33 million CT patients receiving IV contrast annually, should 1% develop CIN, 330,000 patients would be affected. Clinical studies on inpatients have shown a 34% mortality rate for patients who developed CIN.[1] Thus, the potential for patients to develop and suffer serious harm from CIN is significant.

Speed vs. safety: Where's the compromise?

The hospital-based CT department is charged with moving patients through the scanning process rapidly. Getting the images to the radiologist quickly and efficiently has become foremost, minimizing report turnaround time. With the radiologist's report in hand, emergency department patients can be treated and discharged fast, outpatients can return to work or play and inpatients' progress can be managed more effectively.

But few hospitals are screening patients for their potential to develop contrast-induced nephropathy. According to the United States Pharmacopeia's 6th annual MEDMARX Data Report, "The highest percentage of harm from medication—7 times higher than all other medication errors studied in the 2000-2004 period"—occurred in the imaging services department.[2]

Imaging patients are scheduled, walk in, or arrive by ambulance and are prescribed to have any number of imaging exams. More likely than not, little relevant clinical information or adequate history is provided. As imaging departments are under production pressure to do the CT tests quickly, it's not difficult to see why errors occur. But patient safety must come first.

> "Since the 1970s, CIN has been recognized as a potentially fatal adverse drug event resulting from systemic contrast administration—yet the need to identify patients at high risk of developing CIN is relatively ignored."

CT providers should become patient safety advocates

Healthcare professionals involved in CT can save lives by focusing on patient safety in partnership with other departments. Reducing the incidence of contrast-induced nephropathy will require team members across many disciplines working together to provide CT examinations in a culture of safety. Patients should be screened for factors known to make them high-risk for CIN.

Medications used in the imaging department are considered high-risk, yet pharmacists at many healthcare organizations do not perform medication reconciliation, nor is the patient's medication profile reviewed for drug interactions or drug-disease contraindications.

Pharmacists are a key part of CT patient safety

The pharmacist's role is paramount in identifying patients at high risk for CIN. Pharmacists should work closely with imaging departments, informing them of any potentially nephrotoxic drugs the patient is taking, as well as possible drug interactions with contrast—including over-the-counter, non-prescribed medications.

What is the role of the laboratory?

Partnering with the lab can result in a reliable, rapid assessment of the patient's renal function, an important parameter to determine before administering contrast. According to the National Kidney Foundation, chronic kidney disease (CKD) is a major public health problem.[3] Twenty-six million American adults are known to have chronic kidney disease and millions more may be undiagnosed or at risk.[4] Thus, all patients scheduled to undergo a CT exam should be screened for renal function.

The estimated glomerular filtration rate (eGFR) is calculated by the results of the serum creatinine, in addition to the patient's age, sex, and race.[5] An eGFR below 60 indicates stage 3 of chronic kidney disease. The lower the eGFR, the higher the patient's risk factor. Because the imaging department typically does not have a patient's thorough clinical history, staff must rely on the eGFR to assess kidney function.

Ask each patient these health questions to screen for CIN risk

1. Do you have diabetes, congestive heart failure, vascular disease, or allergies?
2. Have you been treated for kidney disease or had kidney surgery?
3. In the last 3 days, have you had an x-ray test that required an injection of contrast dye?

The effect of systemic contrast on the kidneys does not peak for 72 hours post-injection. Patients who have multiple systemic injections within 3 days are at extremely high risk for developing a potentially fatal CIN complication.

If the answer to any of these questions is "yes," the patient must undergo further evaluation before CT can be given.

What is the radiologist's role in preventing CIN?

Radiologists can help identify patients at high risk of developing CIN by reviewing the eGFR, the medical history from the referring clinician, the drug history from the pharmacy, and the patient's answers to the screening questions.

Gathering this information is essential for the radiologist to be able to make make appropriate recommendations. If a patient has risk factors for CIN, the radiologist can assess the risks and benefits of CT with the referring clinician and possibly recommend alternative imaging or order a CT without systemic contrast.

When the radiologist provides patient-specific direction to the technologist, the CT examination can be customized for the patient's condition without sacrificing quality or safety. The technologist's ability to reduce the volume of contrast delivered to all patients without sacrificing image quality can then help reduce the incidence of contrast-induced nephropathy.

Minimizing the damage of CIN

As with many diseases, early detection can help mitigate the damage of CIN. If there is any concern, testing a CT patient's serum creatinine 48 to 72 hours after contrast administration can usually detect CIN and allow the healthcare team to "treat it early."[6]

Teamwork and a multidisciplinary approach can meet the challenge of reducing CIN risk despite increasing numbers of CT scans. Healthcare providers can achieve efficient, reliable, and safe CT studies. As radiologic technologists Michael Beard, Lysa Bejami, Patricia Sauerman, and Jean Guillaume at Mariners Hospital in Tavernier, Fla noted in a June 2009 discussion, the participation of every member of the healthcare team is crucial "for the patient's sake to prevent CIN." **NPSF**

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Mariners Hospital has received a Stand Up for Patient Safety Management Award for its CIN awareness program. For more information, visit: http://www.npsf.org/pr/pressrel/2009-5-22_1.php

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Reading Groups: A Simple and Effective Tool for Promoting Patient Safety

BY KATYA LOSK, MPH, PATIENT SAFETY PROGRAM MANAGER, MEMORIAL SLOAN-KETTERING CANCER CENTER

Like many hospitals across the country, New York's Memorial Sloan-Kettering Cancer Center (MSKCC) is promoting 2 core elements of a patient safety culture: reporting and learning. Staff must feel comfortable reporting errors and near misses, and the institution must learn from its adverse events and plan improvements based on identified areas of vulnerability.

Since the mid-1990s, voluntary reporting systems have proliferated across the US, yet there is no standardized method of handling these reports and little is known about how the information is used to drive safer practices.[1,2]

> "By reading and discussing events and near misses ... rather than reviewing each one independently, staff and management can more easily identify trends and pinpoint areas that need improvement."

Fostering a reporting culture at MSKCC

In early 2007, MSKCC adopted a Web-based reporting system as the foundation for a reporting culture. MSKCC named its application of the tool "Reporting to Improve Safety and Quality," or RISQ. Features of effective adverse-event reporting systems widely found in patient safety literature include:

- Reporting from a variety of staff
- Timely review of reports
- Sharing of organization-wide actions taken with staff[3]

RISQ: A system for reviewing and analyzing incidents

RISQ has exponentially increased the reporting of near misses and events throughout MSKCC. In 2008, more than 6,000 events and near misses were reported by both clinical and nonclinical staff, including nurses, pharmacists, physicians, licensed technical staff, operational staff, and others.

Given the volume of reports and their diversity—from care coordination lapses, to extravasations (accidental administration of intravenously infused medicinal drugs into the surrounding tissue), to specimen mislabeling—the need for a systematic method for reviewing and analyzing incidents became apparent.

As many involved in patient safety know, reporting is only the first step in the process. Reporting alone will not improve patient safety. The challenge then becomes how to promote and sustain a learning culture, and how to ensure that all events and near misses receive appropriate follow-up and discussion.

Reading groups: A strategy to analyze and learn from events

For MSKCC, the answer to this challenge lies in a simple concept called reading groups: organized, multi-disciplinary teams of clinical staff and operational managers who meet regularly to read aloud the events and near-miss descriptions related to a chosen topic or clinical area. By reading and discussing events and near misses reported over a designated time frame (eg, a month or quarter), rather than reviewing each one independently, staff and management can more easily identify trends and pinpoint areas that need improvement.

Developing reading groups as a patient safety tool was an idea proposed by MSKCC's director of patient safety. The director then collaborated with the quality department and clinical and operational directors and managers to assemble teams of staff best suited to address specific topics. Effective reading groups must involve both frontline staff who know the workflows and workarounds, as well as mid-level management and representatives from quality and safety.

Most of MSKCC's reading groups are multidisciplinary, as the issues rarely involve only one department or one job role. For example, the medication safety reading group includes physicians, pharmacy staff and managers, and staff nurses, as well as representatives from informatics, nursing quality assurance (QA), hospital QA, and patient safety.

There are 7 core reading groups—focused on falls, medication, chemotherapy, peri-operative, regional sites, special topics, and QA/safety—and smaller unit-level groups groups are also emerging. For example, many nursing units have started to bring staff together to read through their incidents, talk about how the events could have been

prevented, and look for possible trends. These unit-based groups are essential to maintaining continual engagement with frontline staff to promote patient safety initiatives.

Reading groups identify patterns and potential for harm

The ultimate goal of reading groups is to increase patient safety by detecting patterns in the reported cases and then identifying opportunities to create performance improvement projects to reduce error. One such project was developed by the medication safety reading group.

This reading group detected a number of incidents involving patient-controlled analgesia (PCA) by reading the incident reports aloud. Next, they created a report of PCA-related incidents and sorted the incidents according to where in the medication management process the event occurred.

The medication safety reading group then assembled a separate project team assigned the task of reducing PCA-related errors. This team included nurses with expertise in pain management, pharmacists, and a physician from the pain and palliative care service.

The PCA team has been able to pinpoint several key areas for improvement and is working on implementing solutions. As this example shows, some issues discovered through reading groups require forming a separate performance improvement team; other changes can be made directly by reading group members. The group's workflow depends on the scope of the issue identified. The chart below outlines the work group process.

Reading groups help avoid information silos

While reading groups are not yet widespread, they are not unique to MSKCC. In the book *To Do No Harm: Ensuring Patient Safety in Health Care Organizations*, Julianne Morath describes how the reading groups at Children's Hospitals and Clinics of Minnesota, where she formerly worked, form an integral component of the patient safety initiative.[4]

By sharing stories, staff can learn about incidents in other areas and work together to identify trends and solutions rather than working in silos, as is too often the case. At MSKCC, reading groups are helping to improve communication among staff and managers throughout the hospital's units and work areas.

The beauty of reading groups is their versatility and applicability to any healthcare setting. All that is required to initiate a reading group is to have event and near-miss data and staff who are dedicated to improving the quality of care and patient safety. **NPSF**

How patient safety reading groups work[5]

To form a reading group:

1. Identify the topic.
2. Select the group members.
   - Managers and frontline staff
   - Multidisciplinary
3. Schedule biweekly or monthly standing meetings.

To conduct a reading group meeting:

1. Read event descriptions aloud.
2. Identify inconsistencies in practice or repeated errors.
3. Compile a list of problems.
4. Identify trends.
5. Forward findings to appropriate managers and councils for further discussion.

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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, 268 Summer Street, 6th Floor, Boston, MA 02210-1108. Materials, inquiries, and subscription requests for the publication will be accepted electronically at info@npsf.org *or via fax at (617) 391-9999.*

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Patient Safety Leadership Fellowship is a year-long intensive learning experience designed for healthcare professionals to develop their abilities as patient safety leaders. Fellows participate in an interactive learning community and experience a varied curriculum including independent fieldwork, self-study, and week-long retreats.

Each Fellow designs an Action Learning Project that promotes translation of new knowledge and skills into practice.

The Patient Safety Leadership Fellowship is sponsored by the American Hospital Association and NPSF, in partnership with the Health Research and Educational Trust, Health Forum, the American Society for Healthcare Risk Management, the American Organization of Nurse Executives, and the Society of Hospital Medicine.

The application deadline is February 15, 2010. For details and application requirements, visit *www.ahafellowships.org* or e-mail *fellowships@aha.org*. NPSF

NPSF Welcomes 2009-2010 Leadership Fellows

Julie Briggs, RN
Deputy Director, Nursing Quality and Patient Safety
SUNY Upstate Medical University
Project: Creating a Culture of Safety in Reference to Reporting Medication Events

Lisa Anne Calder, MD, MSc, FRCPC
Associate Scientist, Emergency Medicine Research
Ottawa Health Research Institute
Project: Understanding Disposition Decision Making in the Emergency Department

Ilene Corina
President/Patient Safety Consultant
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Margaret Curtin, MPA, HCA, CPHRM, FASHRM
Director, Risk Management & Education
Michigan Professional Insurance Exchange
Project: Quilting Quality Process into Ambulatory Care for Improved Patient Safety

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The Valley Hospital
Project: Implementation of Initiatives to Reduce Incidence of Elective Labor Induction Prior to 39 Weeks Gestation

Brooke Allison Karlsen, RN, MSN
Director, Surgical Services
St. Vincent's Medical Center
Project: Implementing a Care Partner Program on Inpatient Surgical Units

Lucia M. Lajcsak
Patient Safety Officer
Charles Cole Memorial Hospital
Project: The Role of Middle Managers in Improving Health Care Reliability

Joan L. Miller, MT (ASCP), MHSA
Six Sigma Black Belt
Fairfield Medical Center
Project: Improving Utilization of Event Reporting at Fairfield Medical Center

Anne M. Pato, BS
Quality Compliance Administrator, Department of Psychiatry
Contra Costa Regional Medical Center
Project: Implementation of a Just Culture at Contra Costa Regional Medical Center

Matei Petrescu, MD
Assistant Professor, Pediatric Critical Care
Tulane School of Medicine
Project: Standardizing of the Sign-Out Process of Pediatric Critically Ill Patients and Improving the Sign-Out Culture

Margaret A. Rykowski, MPA, MSN
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Project: Implementation of a Just Culture at San Francisco General Hospital and Trauma Center