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PRESENTATION TITLE

Presentation Subtitle

Agenda:

- Hospital Example
- Incident Reporting
- Just Culture
- Barriers to Incident Reporting

2/17/20

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A Tale of Two Hospitals: Which is Yours?

- Mrs. Smith, a patient on the evening shift in a Medical -Surgical ward, is complaining of pain in her back and is requesting to be repositioned in bed. She appears to have slid down a little, and would benefit from being repositioned, but she is too weak to reposition herself. The Nursing Assistant that answered her call light notes that Mrs. Smith is very large, so she looks for the proper lifting equipment for larger patients, but cannot find any slings that will fit Mrs. Smith. After notifying her Nurse, and making a second attempt to find the correct sling, it is decided that the Nurse, and two Nursing Assistants will pull Mrs. Smith up in bed manually. The lift is completed, but one of the Nursing Assistants feels a pull in her lower back, and an hour later feels some pain with walking and sitting. At the end of the shift, the Nursing Assistant tells the Charge Nurse about her injury, and completes the Incident form online as instructed. Since Employee Health is closed, the Nursing Assistant will go home and will take some Motrin to see if its better in the morning (she does not think it is serious enough to go to the Emergency Department).

A Tale of Two Hospitals: Hospital A

- **Hospital A:** Online Incident form is reviewed by Risk Management and sent to the Med/Surg Manager, who is on vacation. When the Manager returns a week later, she sees the report and asks the dayshift Charge Nurse about the incident (she was covering the Unit during the Managers vacation). The Charge Nurse does not know why the staff could not find the correct sling for obese patients, but assures the Manager that they are in the closet now. The injured Nursing Assistant was off for a few days after the incident, but then called out sick for her next two shifts. No one from the Unit has spoken to her since then. The Manager calls the employee and finds out she has been seeing a Chiropractor for her back pain, and is not sure when she will be able to work. She hasn't called Employee Health yet, and wants to know about filing a Workers Comp claim. The Manager completes the incident investigation and attributes the injury to Employee error, for not using the correct equipment. The employee is then reprimanded.

A Tale of Two Hospitals: Hospital B

- **Hospital B:** The Charge Nurse, upon hearing of the incident, immediately assesses if the employee needs to seek emergency treatment, and then asks the employee what she thinks contributed to this injury, documents her conversation, and notifies the day Charge Nurse who is covering for the Manager (while she is on vacation). The Employee leaves a message for Employee Health so that they will be able to track her injury. Employee Health contacts the employee the next morning, and advises her on treatment options, and completes the first report of injury for Workers Comp. Risk Management reviews the incident, and verifies that the employee is receiving proper medical treatment, Employee Health is monitoring her progress, Workers Comp has been filed, and the covering Charge Nurse is conducting the incident investigation until the Manager returns. Information suggests that the slings for obese patients have not been consistently available due to an ongoing disinfection issue (and number of the these slings is limited). Ultimately it is found that the number of slings is not adequate, and the process for disinfection needed to be improved. Nursing staff are educated on all the findings.

What Were the Differences Between Hospital A and B?

- **Hospital A** – did not have any clear process for how to handle injured workers, which delayed the incident investigation, and delayed appropriate medical treatment. Staff did not know their role and responsibilities in the safety system. Injury investigation was only superficial, and the conclusion blamed the worker without finding out why the injury occurred, or making any meaningful changes to prevent it from happening again.

What Were the Differences Between Hospital A and B?

- **Hospital B** – had a clear process in place for safety incidents, in which all staff knew their responsibilities. Staff at all levels were empowered to be engaged in safety activities (such as accident investigation). Medical treatment of the injured worker began immediately after the injury, and management was fully engaged in determining the root cause, and finding a remedy, which was then communicated to the staff.

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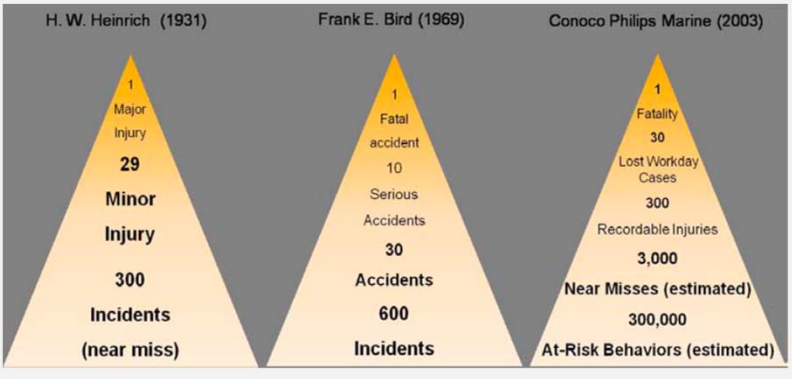
The Issue of Underreporting

- Safety Pyramid



Reprinted from Sustainable Safety Management - Incident Management as a Cornerstone for a Successful Safety Culture. Freibott, B. (2012). The Monitor. www.asse.org

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Barriers to Reporting an Incident

- **The Top 9 Reasons Workers Don't Report Near Misses**

1. **Fear** – punishment for injury, loss of job
2. **Embarrassment** – being humiliated or labeled "frequent flyer"
3. **Difficulty** – process to report not easy
4. **Bureaucracy** – worker may have to do extensive follow-up, etc.
5. **Peer Pressure** – may ruin safety record, etc.
6. **Loss of Reputation** – workers don't want their peers to know they were injured
7. **Its Easier Not To** – if workers think no one cares, or if its difficult to report, or if attitude is "its no big deal"
8. **Lack of Interest From the Organization** – when workers believe Management does not take it seriously, or consider it important
9. **Perceived as Pointless** – if Management thinks that near misses are not particularly important

- Adapted from NSC 2011: The Top 9 Reasons Workers Don't Report Near Misses. From a presentation to NSC by Philip La Duke. EHS Today. www.ehstoday.com

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Early Warning Systems / Incident Reporting Systems

Early Warning Systems

- Center around Reporting of Incidents and Events Identified by:
  - Staff
  - Patients
  - Families
  - Others

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Formal Incident Reporting

- Promote patient safety throughout the organization
- Address trends or challenges that threaten the safe delivery of patient care

Two types of Internal Reporting Systems

- Electronic Systems
- "Paper" Systems

Key Elements of Internal Reporting "System"

- Document patient feedback
- Manage claims
- Document root-cause analysis
- Consistent utilization / documentation / reporting
- Ability to enter "free text"

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The Best Incident Reporting Tool…

- Is the one that gets used and then acted upon!

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Information Tracked in Incidents Reports

- Patient Information
  - Demographics
  - Socioeconomic Data
- Staff Information
  - All staff members involved
  - Names and credentials
  - Department / specialty
- Facility / Organization Information
- Description of Incident

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Key Reporting Guidelines / Policy

- What is to be reported
  - Define an "incident"
- Stick to the Facts
  - Avoid finger-pointing and conclusions
- Report Timely
  - 24-hour rule
- Who should submit the report
  - Define the primary reporting responsibility

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Defining an "Incident"

- Diagnosis Errors
  - Failure to diagnose
  - Timeliness
  - Misdiagnosis
- Surgical Occurrences
  - Wrong patient
  - Wrong site
  - Wrong Procedure
  - Incorrect sponge count
- Blood-Related Occurrences
  - Wrong type administered
  - Transmission of disease through blood products
- IV-Related Incidents
  - Wrong solution administered
  - Incorrect infusion rates
- Treatment-Related Events
  - Reactions to contract materials
  - Burns from improper use of hot packs
  - Improper exposer to x-ray
- Medication-related occurrences
- Falls
- Employee Injury

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Other Opportunities for Risk Review

- Occurrence Screening
  - Pro-Active Reviews
  - Internal "audit" for compliance with policies, procedures and standards of care
- Informal Reporting
  - Review of medical malpractice claims
  - Patient satisfaction surveys

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Internal Report Analysis

- Identify Trends and Risk
  - Patient age / demographic
  - Diagnosis / procedure
  - Department
  - Employment type for staff involved (full-time, locums, part-time)
- Failure Mode and Effect Analysis (FEMA)
  - Analyze current processes
  - Potential for change / improvement
  - Track outcomes / progress toward change
- Root Cause Analysis (RCA)
  - Reactive approach
  - Performed after an incident

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Defining medication errors

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to:

- professional practice
- health care products
- procedures and systems
- product labeling, packaging, and nomenclature
- dispensing
- distribution
- administration
- education
- monitoring

National Coordinating Committee-Medication Error Reporting and Prevention (NCC MERP); accessed at http://www.nccmerp.org/aboutMedErrors.html; Jan. 2012.

Collaboration on Proactive Patient Safety Initiatives

- Culture of Safety
  - AHRQ Survey
  - Tool "Survey on Patient Safety Culture"

http://www.ahrq.gov/sops

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Moving toward a safer culture

James Reason

- Goal: to create a safer culture consisting of:
  - Reporting
  - Learning
  - Flexibility
  - Just Culture
- Swiss Cheese Model

David Marx

- Just culture algorithm – systems, behavioral choices, injury severity & not blame-free but just
- Core principles:
  - To err is human –human errors, systems
  - To drift is human – well intentioned, cut corners, fast paced, creates risk
  - Risk is everywhere
  - We are all accountable

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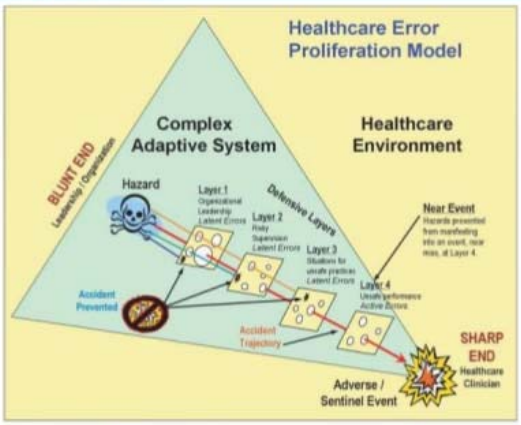
Reason's Swiss Cheese Model
(emeraldinsight.com)



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Just Culture – Human Error

The single greatest impediment to error prevention
in the medical industry is
"that we punish people for making mistakes."

Dr. Lucian Leape
Professor, Harvard Medical School of Public Health
Testimony before Congress on Health Care Quality Improvement

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Just Culture

1. Emphasizes quality and safety over blame and punishment.
2. Promotes a process where mistakes/errors do not result in automatic punishment but a process to uncover the root cause of the error.
3. Human errors that are not deliberate or malicious result in coaching, counseling, and education to decrease the likelihood of a repeated error.
4. Promotes increase error reporting that leads to system improvements to create safer environments for patients and staff.

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"To address this mistake we need to utilise our thorough system of root cause analysis. I will begin, if I may, by pointing out that it's not my fault."

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Patient safety guidelines

- **AHRAQ** : Agency for Healthcare Research and Quality
- **NQF**: National Forum for Quality Measurement and Reporting
- **NHS**: National health and Safety
- **NPSA**: National Patient Safety Agency
- **WHO**: World Health Organization

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Patient safety???

- First, ***do no harm*** – Safety is the most basic dimension of performance necessary for the improvement of healthcare quality.

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Just Culture Algorithm

The organization adopting safety culture

- Committed to ongoing learning & flexible to **accommodate changes**
- Encourage **team work**
- Encourage & **reward reporting**
- Focus on **system & process** rather than individual
- **Respect** people working in the organization regardless of their position.
- **No blame culture**
- **Proactive**

Barriers to Communication

- Competition for time and attention
- Multiple levels of Hierarchy
- Power / Status of relationships
- Managerial philosophy
- Beliefs, Values, and Prejudices
- Fear
- Lack of Empathy
- Status Quo

- Organizational Behavior in Healthcare. (2011). Borkowski, N. Chapter 4. Workplace Communication. Source: Managing health services organizations. 4th Ed. Longest, Rakish, Darr. (2000).

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Overcoming Barriers to Communication

- Devote adequate time and attention to listening
- Reduce the number of levels or links in the hierarchy
- Change organizational philosophy to encourage the free flow of communication
- Use multiple channels, and reinforce complex messages
- Consciously tailor words to make message understandable
- Recognize that others have their own perception
- Engage in Empathy

- Organizational Behavior in Healthcare. (2011). Borkowski, N. Chapter 4. Workplace Communication. Source: Managing health services organizations. 4th Ed. Longest, Rakish, Darr. (2000).

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Competing Priorities

- Are Nurses and Nursing Assistants supposed to put patient safety first, and their own safety second?
- Is injury really "part of the job"?
- Why can't we **do both?** Why can't worker safety and patient safety be **equally important**?
- Lets think about that…. what are the barriers to prioritizing worker and patient safety?

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Examples of Safety Interventions and Benefits to Both Patients and Workers (cont.)

Intervention Focus	Examples of Strategy	Benefits to Patients	Benefits to Workers	Benefits to the Organization
Appropriate Staffing Levels, Staffing Mix and Workload	Staffing Committees, work-hour and/or shift length restrictions, rest periods	Lower mortality, fewer adverse events, increased patient satisfaction	Decreased stress and burnout, enhanced morale, quality work-life balance	Increased retention, decreased absenteeism, improved satisfaction scores
Improving Safety Culture and Teamwork	Engaging Workers and Patients in Safety activities, Joint Safety rounds, daily safety huddles	Fewer adverse events, increased satisfaction	Enhanced employee morale and satisfaction, decreased fatigue and injury	Improved patient and worker outcomes, decreased litigation, improved reputation

Adapted from Improving Patient & Worker Safety: Opportunities for Synergy, Collaboration & Innovation. TJC (2012)

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Protecting Sensitive Information

- Peer Review Privilege
  - MT Code Annotated 37-2-201
- Patient Safety and Quality Improvement Act of 2005

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