

Quality & Patient Safety Fellowship

INTRODUCTION TO PATIENT SAFETY


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Intro to Patient Safety

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Crossing the Quality Chasm

- **Safe:** avoiding injuries to patients from the very care that is intended to help them.
- **Timely:** reducing harmful delays for patients and providers.
- **Effective:** providing evidence-based care to those who benefit; avoiding ineffective or harmful care.
- **Efficient:** reduce waste – time, supplies, ideas, energy.
- **Equitable:** ensuring care quality does not vary because of race, language, gender, geography, income, or other factors.
- **Patient-centered:** providing care that is respectful of and responsive to patient preferences, needs, and values.

<https://nap.nationalacademies.org/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the>

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Harm in Healthcare

Unintended physical injury caused by medical care.

Requires additional monitoring, treatment, hospitalization, or results in death.

Harm comes from care provided, not from absence of care.

(IHI definition)

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1 in every 10 patients is harmed in health care.



The diagram consists of 10 stylized human icons arranged in two rows. The top row has six icons and the bottom row has four icons. The first icon in the top row is colored red, while all other icons are a muted green color. This visualizes the statistic that 1 out of every 10 patients is harmed in health care.

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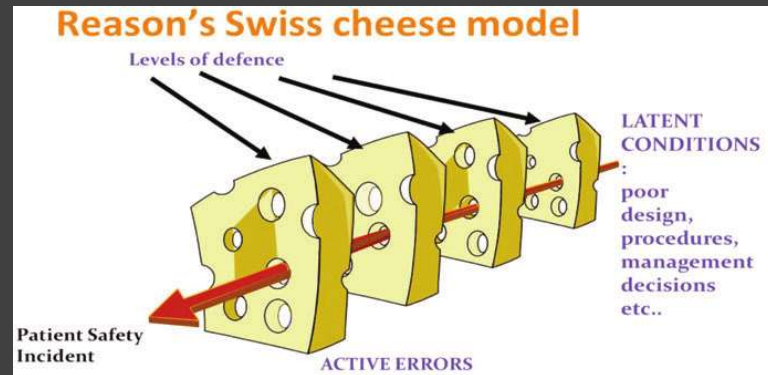
“Swiss Cheese” Theory

Active Failures:

- Errors occurring at the point of care
- Visible, frontline mistakes Usually the final step before harm

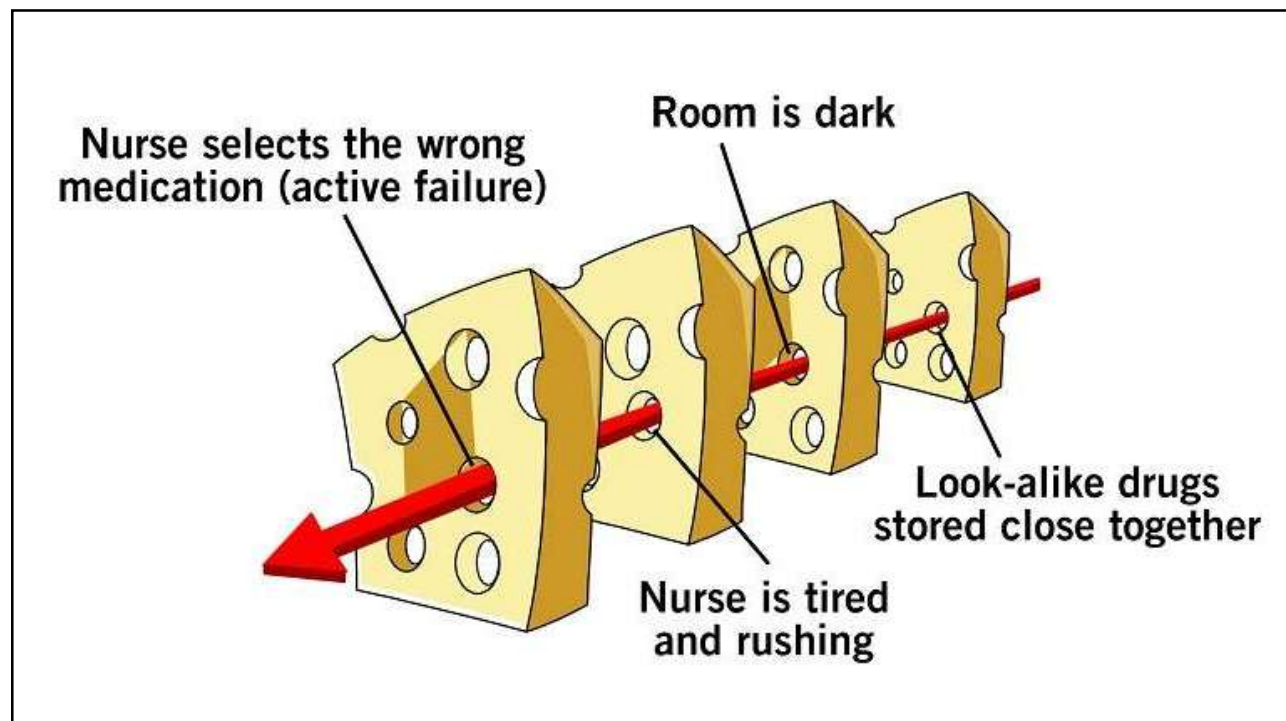
Latent Failures:

- Hidden system weaknesses in processes, design, or culture
- Create conditions that make active failures more likely
- Often unnoticed until combined with frontline error



(Reason, 1991)

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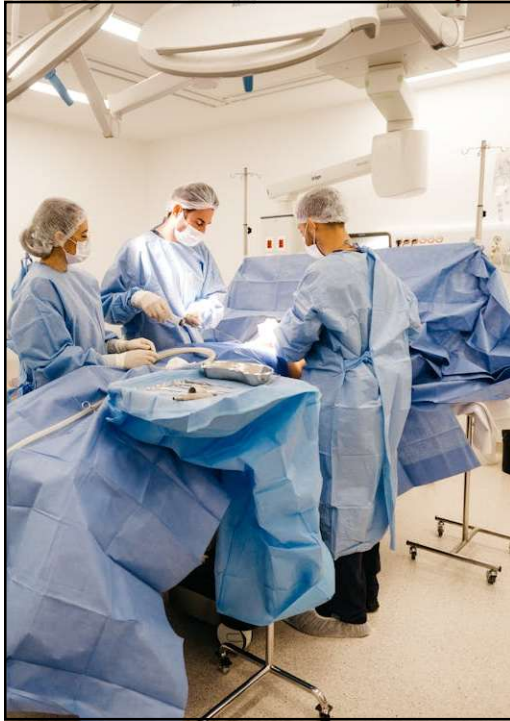
Human Error	At-Risk Behavior	Reckless Behavior
<p><i>Product of Our Current System Design and Behavioral Choices</i></p> <p>Manage through changes in:</p> <ul style="list-style-type: none"> • Choices • Processes • Procedures • Training • Design • Environment 	<p><i>A Choice: Risk Believed Insignificant or Justified</i></p> <p>Manage through:</p> <ul style="list-style-type: none"> • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness 	<p><i>Conscious Disregard of Substantial and Unjustifiable Risk</i></p> <p>Manage through:</p> <ul style="list-style-type: none"> • Remedial action • Punitive action
Console	Coach	Punish

Source: American College of Cardiology

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Culture of Safety

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What is a Culture of Safety?

A culture of safety is an atmosphere of **mutual trust** where all staff can **speak openly** about safety issues **without fear of blame or punishment.**

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Features of a Culture of Safety

Psychological safety

Just Culture and Fairness

Leadership Support

Communication & Collaboration

Learning Culture

Transparency & Feedback Loops

Equity and Inclusion

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Tools to Reduce Harm

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Prospective

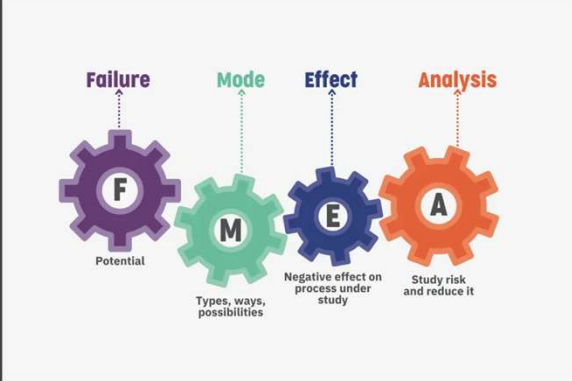
help us identify where harm could occur *before* it happens

Retrospective

help us learn from events *after* they occur

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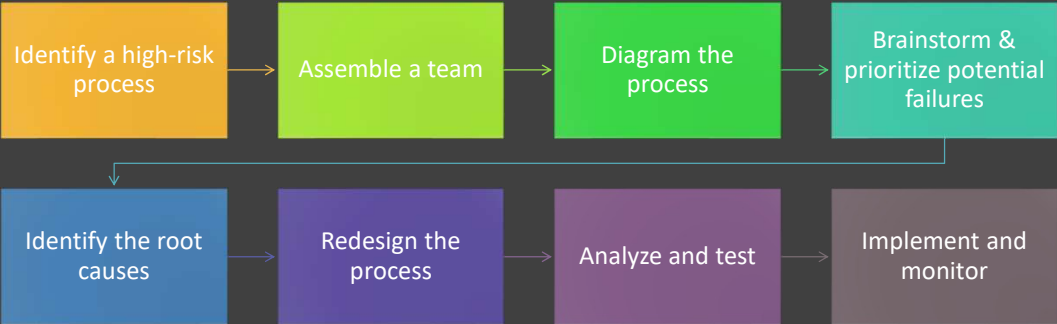
Prospective: Failure, Mode, & Effect Analysis



Systematic, proactive method to assess risk of failure and harm in processes and to identify the most key areas for process improvements.

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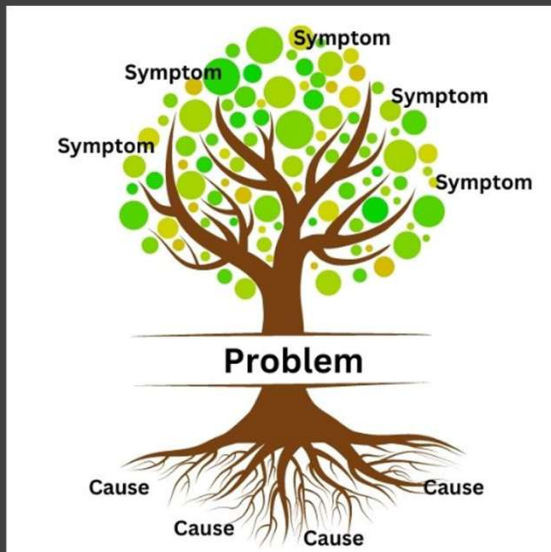
Elements of a FMEA



```

graph LR
    A[Identify a high-risk process] --> B[Assemble a team]
    B --> C[Diagram the process]
    C --> D[Brainstorm & prioritize potential failures]
    D --> E[Identify the root causes]
    E --> F[Redesign the process]
    F --> G[Analyze and test]
    G --> H[Implement and monitor]
  
```

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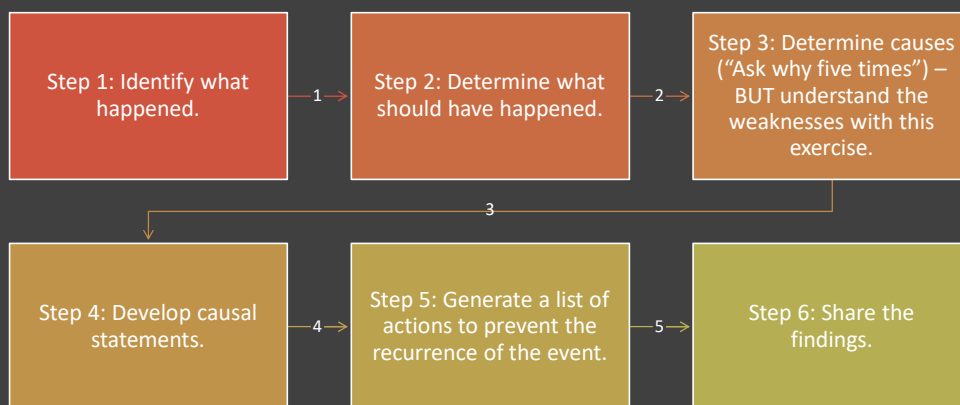
Retrospective: Root Cause Analysis

- A *root cause analysis* (RCA) is a systematic approach to understanding the causes of an adverse event and identifying system flaws that can be corrected to prevent the error from happening again.

Image source: [Workfellow](#)

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RCA Steps



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Effective Root Cause Analyses

- Use structure and tools to clarify the timeline and contributing factors
- Compare the process as designed vs. as actually performed
- Analyze differences through a human-factors lens
- Focus on process causation, not individual blame
- Identify actionable improvements to reduce risk

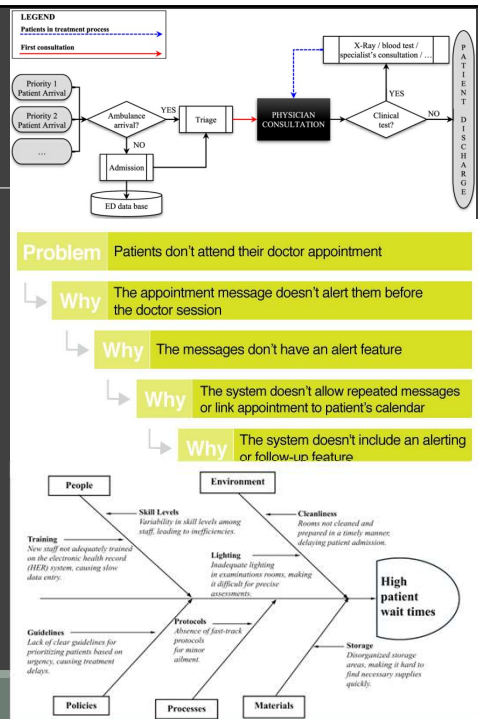
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Other Tools

Flowcharting : mapping the timeline and actual vs. ideal process

The 5 Whys: drilling down to contributing factors

Fishbone/Ishikawa diagrams: categorizing causes into system areas



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Communication

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Critical Language

Set of agreed-upon terms that members of the team use when clarity is needed.

I am **C**oncerned
I am **U**ncomfortable
This is a **S**afety issue
Please, I **N**eed...

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Structured Communication



Supports efficient and effective communication between teams.

Helps teams plan for care, respond to changes in care plans or patient conditions, and build situational awareness among all team members.

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SBAR is a technique designed to communicate critical information succinctly and briefly.



Situation
What's going on with the patient right now? (Identify yourself, identify the patient, state the problem concisely.)

Background
What's the background on this patient? How did we get to this point? (Review the chart, anticipate questions, state the relevant medical issues.)

Assessment
What do I think the issue is? Why am I concerned? (Provide your observations and evaluations of the patient's current state.)

Recommendation
What should we do to respond to the situation? (Suggest what should be done to meet the patient's immediate needs.)

Response
Collaboration resulting in a plan of action. (Listen, for/seek feedback to ensure responder understands the issue.)


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SBAR

SBAR is a common form of structured communication used most frequently in health care to communicate about a patient between one provider and another.

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Teach Back

Method to confirm that communication from another has been heard and understood.

- Step 1: The sender concisely **states** information to the receiver.
- Step 2: The receiver then **repeats** back what he or she heard.
- Step 3: The sender then **acknowledges** that the repeat back was correct or makes a correction.
- Step 4: The process continues until participants **verify** a shared understanding.

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Briefings and Debriefings

Briefing: Quick check-ins to provide a regular opportunity for front-line staff to share and discuss safety concerns. usually involve taking a minute or two to discuss the plan and the expected outcome.

Debriefing: Concise exchange that occurs after such events have completed — to identify what happened, what the team members learned, and what they can do better next time

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Human Factors

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Human Factors & Human Factors Engineering




The science of **human factors** is the study of “the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work”



Human factors engineering is the design of facilities, equipment, and processes to promote safety, while keeping human characteristics in mind.

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Design Principles

- Simplify
- Standardize
- Use forcing functions and constraints
- Use redundancies
- Avoid reliance on memory
- Take advantage of habits and patterns
- Promote effective team functioning
- Automate carefully

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Response

RESPONDING TO ADVERSE EVENTS

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Response

- Compassion for patients and families
- Support for caregivers
- Systematic process for learning and improving

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Step by Step Response Approach



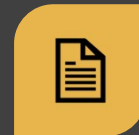
STEP 1: CARE FOR THE
PATIENT.



STEP 2:
COMMUNICATE WITH
THE PATIENT.



STEP 3: REPORT THE
EVENT TO
APPROPRIATE PARTIES.



STEP 4: DOCUMENT IN
THE MEDICAL RECORD.

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Communicating an Adverse Event

- Acknowledge what happened.
- Share what is known at the time
 - Express sympathy and regret
 - Outline next steps
- Reassure patient and family that the organization will learn from the event.

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The Second Victim

Caregivers need:

- Early identification that they're struggling
- Emotional support from peers
- Gossip control, so the story doesn't spiral or cause further harm
- The chance to be part of improvement efforts, so something meaningful comes from their experience

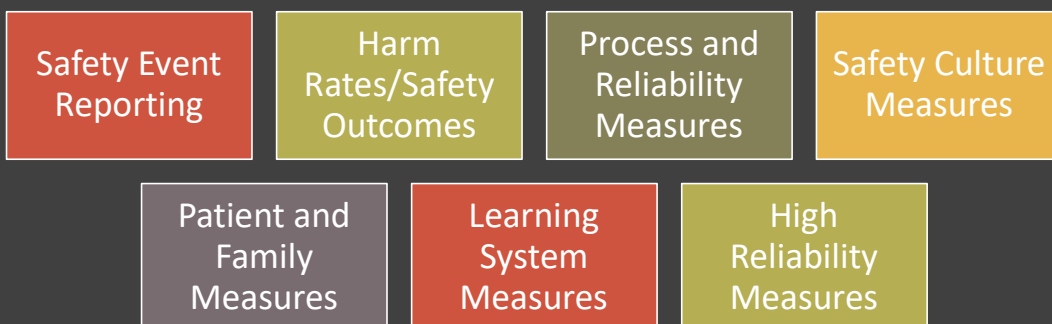


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Measurement

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Measuring Patient Safety



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2026 Critical Access Hospital National Performance Goals (NPGs)

- Goal 1 The critical access hospital ensures that the correct patient receives the correct care at the correct time.
- Goal 2 The governing body and leadership team foster a culture of safety.
- Goal 3 The critical access hospital has an emergency management program.
- Goal 4 The critical access hospital prioritizes excellent health outcomes for all.
- Goal 5 The critical access hospital prioritizes infection prevention and control.
- Goal 6 The critical access hospital prioritizes pain management and safe prescribing practices.
- Goal 7 The critical access hospital respects the patient's right to safe, informed care.
- Goal 8 The critical access hospital reduces the risk for suicide.
- Goal 9 The critical access hospital develops and implements safe transplant practices.

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- Goal 10 The critical access hospital performs waived testing in a safe and consistent manner.

*Note: Waived tests are categorized by CLIA as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." The Food and Drug Administration (FDA) determines which tests meet these criteria when it reviews a manufacturer's application for test system waiver. The list of FDA-approved waived tests can be accessed at the following link:
<https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm>.*

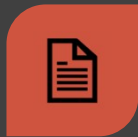
- Goal 11 The critical access hospital maintains workplace and patient safety.
- Goal 12 The critical access hospital is staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care.
- Goal 13 The critical access hospital safely performs imaging services.
- Goal 14 The critical access hospital has a medication management program that focuses on safety.

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What's Next?

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It's Your Turn!



Complete the slide template provided by MHA.



Send your completed slide deck to Jennifer and Casey by end of day Tuesday, March 24.




Present your slides on Thursday, March 26.



Your presentation should be 5–7 minutes.

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Questions & Contact

Reach out anytime!
Jennifer Wagner
jwagner@convergencehealth.org

The image features a graphic of ten stylized hands of various colors (orange, black, yellow, teal, blue, and dark blue) raised against a light background. The hands are positioned at different heights, with the tallest hand in the center. The entire graphic is set within a dark grey rectangular frame.