In 2009, We Passed the 10 Year Anniversary of the IOM Report – "To Err is Human"

Are Hospitals Safer in 2011?

We don’t really know.

A 2010 Update

13.5% (1 out of every 7) of hospitalized Medicare patients suffer an adverse event

15,000 patients die per month due to medical mistakes

44% of all events rendered as preventable

Annual costs equal to $3.8 billion in Medicare alone

25.1 per 100 admitted patients harmed by adverse drug events

Department of HHS, Nov 2010

Landrigan et al, New Eng J Med, Nov 2010
Creating a Safety Culture

- Expectations
- Accountability
- Level playing field (authority gradient)
- Reporting
- Metrics
### Safety and Quality

**One in the Same**

- Rely on basically the same principles
- High reliability characteristics apply to both
- Improving safety improves quality, and vice versa

### The Basics of a Patient Safety Culture Transformation

#### Prevention

- Learned Behaviors
  - Pay attention to detail
  - Support the Team
  - Questioning attitude
  - Clear communication
- Clear the air
  - Lessen the authority gradient
  - Limit intervention
  - Safe environment for reporting
  - Full transparency

#### Detection

- Develop metrics
  - SSE, PCE, NME, ADE/1000
- Effective reporting
  - Efficient and supported incident reporting
  - Adverse drug events in real time

#### Correction

- Sustainment
How Do We Measure Preventable Harm?

Joint Commission Definition of Serious Event: An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof.

Notice that it avoids the causation question.

Serious Safety Event: those events occurring from a deviation from generally accepted performance standards resulting in moderate to severe patient harm or death.

The SSER is calculated monthly as the number of Serious Safety Events for the previous 12 months per 10,000 adjusted patient days for the same time period.

The Basics of Improving Patient Safety

Correction

Learn the Science
- Human and System Failure mode methodologies
- Taxonomies
- Error types
- Root Cause/Common Cause analysis

Expand RCA expertise to units
Real-time reporting and determination
Full integration with Risk Management
Work as a team
Classify all events in a database
Share transparently and frequently

Flowchart & Guide

Deviation from standard of care: No

Did the deviation reach the patient? No

Near Miss Event

Did the deviation cause more than minor or minimal temporary harm to the patient? Yes

Serious Safety Event

Deviation from standard of care: No

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Serious Safety Event

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Near Miss Event

Did the deviation cause more than minor or minimal temporary harm to the patient? Yes

Serious Safety Event

Flowchart & Guide
Typical Improvement Curve

Mindfulness: Weick

Implementing High Reliability Principles

"Together these processes produce a collective state of mindfulness. To be mindful is to have an enhanced ability to discover and correct errors that could escalate into a crisis."

High Reliability Principles

Clinical Deterioration with Situational Awareness
Pediatric Early Warning

<table>
<thead>
<tr>
<th>Pediatric Early Warning Scoring Tool (PEWS)</th>
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<tbody>
<tr>
<td>Assessment: Height of Rises in the Last 4-6 Hours</td>
<td>Safety</td>
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<td>Tachycardia</td>
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Are we an HRO Yet?

High Reliability Microsystems ("HRU's")

- Nurse-Physician Co-leadership
- Unit level outcomes
- Unit level innovation and improvement
- Learning system across microsystems
- Locus of Prioritization of goals
- High Reliability Unit pilot

Keys to Sustaining a Safety Culture

- Increase physician leadership
  - Safety coaches
  - TeamHRU leaders
  - Lead by example
- Continuous enforcement and support of behaviors
  - They must all become habits
- Start early
  - Nursing and medical students, interprofessional approach
  - Residents
  - Staff orientation
- Keep safety as a priority
  - Regardless of staff changes, revenue crunches, or new leadership
- Staff meetings, safety stories
  - Always reporting events, or non-events
- Constant good catch reporting
- Drive toward high reliability units

Paul Sherak said it best:
"This safety work is hard!"

D'OH!

Paul Sherak for the sake