Hospitals fail short on safety, quality. Leapfrog

Most U.S. hospitals still have a long way to go before they meet even minimum safety and quality standards, according to the 2008 Leapfrog Hospital Survey Results report.

"Health care for so long has operated behind a curtain," she said. "We haven't fully understood the level of quality that we're dealing with."

Indeed, Laurel Pickering, executive director of the New York Business Group on Health, said none of the 50 members of her coalition are using Leapfrog data in the negotiations with insurers and health care organizations.

By contrast, insurers do use the Leapfrog report, along with their own claims data, to determine which hospitals to include in their provider networks, according to an industry spokesman.

We don't really know.

Considerable efforts have been made to improve patient safety and it is natural to ask...are patients any safer? The answer to this simple question is curiously elusive...we believe that the lack of reliable information on safety and quality of care is hindering improvement in safety across the world.

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 equate 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
Naval Aviation Mishap Rate

- Ingled Corns Docks
- Naval Aviation Safety Council
- NAPW wth 1950
- RAG concept
- NAGC 1951
- Certified Flight Programs
- FAA
- HSC 1.64

Average Rate Per Exposure of Catastrophes
and Associated Deaths Per Activity ("Reliability")

- Less Safe
- More Safe
- Critical support to IGA
- Critical support to IGA
- Critical support to IGA
- Critical support to IGA

Creating a Safety Culture

- Expectations
- Accountability
- Level playing field
- (authority gradient)
- Reporting
- Metrics

Creating a Safety Culture

- Transparency
- Physician leadership
- Executive support
- Situational awareness
- High reliability principles
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
Detection
Correction
Sustainment

The Basics of a Patient Safety
Culture Transformation
Prevention
"Creating the Culture"
Learned Behaviors
- Pay attention to detail
- Support the Team
- Questioning attitude
- Clear communication
Clean the air
- Lessen the authority gradient
- Limit intervention
- Safe environment for reporting
- Full transparency

The Basics of a Patient Safety
Culture Transformation
Detection
Develop metrics
- SSE, PCE, NME, ADE/1000
- Effective reporting
- Efficient and supported incident reporting
- Adverse drug events in real time

Effective reporting
Efficient and supported incident reporting
Adverse drug events in real time
How Do We Measure Preventable Harm?

Joint Commission Definition of Sentinel Event: An unexpected occurrence involving death of 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 and 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.

Variation from standard of care that results in:

- Serious Safety Event
- Near Miss
- Precursor Safety Event
- Near Miss Event that almost happened - the error was caught by one last detection barrier

Cause Analysis: Level, Trend, RCA

The Basics of Improving Patient Safety

- Prevention
- 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 transparency and frequency

Sustainment
Typical Improvement Curve

Significant improvement is due to complacency or reverting to old habits.

Long-term improvement is achieved in 1 to 3 years, approximately.

Start of Change Time

Early Adopters Lose the Gains

Case A - Single Hospital
Case B - Multi-Hospital System
Case C - Single Hospital

To Achieve a High Reliability Organization

A strong safety foundation and culture
A safety infrastructure
Real, and actionable metrics
Full transparency
Physician and administrative leadership
Risk management as part of the team

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

Value driven units
Reluctance to simplify
Preoccupation with failure
Defensive to expertise
Sensitivity to operations
Situational awareness
Commitment to resilience

Clinical Deterioration with Situational Awareness

Anticipated trajectory
SA bundles/ daily huddles
Unanticipated clinical deterioration

Admission Assessment

Health status

Dr. Steve Murdoch, MD CCHMC
Not Yet!

Are we an HRO Yet?

Keys to Sustaining a Safety Culture

- Increase physician leadership
  - Safety coaches
  - TeamHRU leaders
  - Lead by example
- Continuous enforcement and support of behaviors
  - They then 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
- Start meetings, safety stories
  - Always reporting events, or non-events
- Consistent good safety reporting
- Drive toward high reliability units

High Reliability Microsystems (HRU)'

- 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

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