Patient Safety is Everyone’s Responsibility
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Objectives

• Know TJC 2016 National Patient Safety Goals
• Discuss human factors on patient safety
• What is your role in patient safety?

Why do we need to report safety issues??
2017 Top 10 Health Technology Hazards

ECRI Institute

Top 10 Patient Safety Concerns for 2016

Click to see what our readers said!

ECRI Institute’s Top 10 Patient Safety Concerns for 2016

1. Health IT configurations and organizational workflow that do not support each other
2. Patient identification errors
3. Inadequate management of behavioral health issues in non-behavioral health settings
4. Inadequate cleaning and disinfection of flexible endoscopy scopes
5. Inadequate test result reporting and follow-up
6. Inadequate monitoring for respiratory depression in patients prescribed opioids
7. Medication errors related to pounds and kilograms
8. Unintentionally retained objects despite correct count
9. Inadequate antimicrobial stewardship
10. Failure to embrace a culture of safety
Preoccupation with Failure

- **EVERYONE** is focused on errors and near misses
- Attention to detail
- How to prevent errors from happening again
- Finding and fixing problems is supported by leadership
Reluctance to Simplify

- WHY, WHY, WHY
- Root Cause Analysis
- Think outside the box
- Bring in front line staff
- Provide all of the necessary training
- Standardization

Sensitivity of Operations

- Situation Awareness
- What is the potential for harm
- FMEA
- Pay attention and speak up

Deference to Expertise

- People closest to the work are the most knowledgeable about the work
- Kaizen events
- Senior leader/manager rounding
- Share concerns
- No Hierarchy
- Provide feedback
Commitment to Resilience

- Assume the system is at risk to fail
- Immediately respond and minimize the harm
- Practice, practice, practice
- Cross monitor each other

Human Factors of Patient Safety

- We are HUMAN!
- We are not perfect.
How to overcome the imperfection

• Checklists
• Standardize processes and eliminate steps
• Knowledge and training
• If you see something, say something!
• Examine close calls and near misses.
• Perform FMEAs
• Be more Proactive instead of Reactive.
• Adopt best practices.
• Make patients active participants in their own care.
• Separate process issues from people issues.

Performance Management Decision Guide

Adapted from James Reason's Decision Tree for Determining the Culpability of Unsafe Acts and the Incident Decision Tree of the National Patient Safety Agency (United Kingdom National Health Service)

Did the individual intend the act?

Would individuals in the same profession and with comparable knowledge, skills, and experience act the same under similar circumstances?

Did the individual depart from policies, procedures, protocols, or generally accepted performance expectations?

Is there evidence of ill health or substance abuse?

Did the individual act with malicious intent (i.e. to cause individual harm or other damage)?

Were there deficiencies in related training, experience, or supervision?

Were the policies, procedures, protocols, or performance expectations available, understandable, workable, and in routine use?

Did the individual have a known medical condition?

Were there significant mitigating circumstances?

Is there evidence that the individual chose to take an unacceptable risk OR has a trend in poor performance or decision making?

(Consult Human Resources)

• Disciplinary action
• Report to professional group or regulatory body
• Law enforcement referral

Identify Contributing System Factors (Consult Human Resources)

• Disciplinary action
• Job-fit consideration
• Console
• Coaching
• Mentor assignment
• Increased supervision
• Performance improvement plan
• Adjustment of duties

Identify Contributing System Factors (Consult Human Resources)

• Occupational health referral
• Adjustment of duties
• Leave of absence

If substance abuse:

• Substance abuse testing
• Disciplinary action

Identify Contributing System Factors

Yes

Yes

Yes

No

No

No

No

No

No

Deliberate Act Test

Incapacity Test

Compliance Test

Substitution Test

Yes

No

No

No

Medical Condition and/or Substance Abuse Possible Reckless or Negligent Behavior Possible Unintended Human Error Possible System Induced Error

Malevolent or Willful Misconduct

2016 National Patient Safety Goals

Joint Commission
The National Patient Safety Goals (NPSGs) were established in 2002 to help accredited organizations address specific areas of concern in regards to patient safety. The first set of NPSGs was effective January 1, 2003. The Patient Safety Advisory Group advises The Joint Commission on the development and updating of NPSGs.

**Background**

- The National Patient Safety Goals (NPSGs) were established in 2002 to help accredited organizations address specific areas of concern in regards to patient safety.
- The first set of NPSGs was effective January 1, 2003.
- The Patient Safety Advisory Group advises The Joint Commission on the development and updating of NPSGs.

**Patient Safety Advisory Group**

- Panel of widely recognized patient safety experts
  - Nurses, physicians, pharmacists, risk managers, clinical engineers, other professionals
- Hands-on experience in addressing patient safety issues in wide variety of health care settings
- Advises The Joint Commission how to address emerging patient safety issues
  - NPSGs, Sentinel Event Alerts, standards and survey processes, performance measures, educational materials, Center for Transforming Healthcare projects

**Patient Identification**

**Goal 1:**
Improve the accuracy of patient identification.

- **NPSG 01.01.01:** Use at least two patient identifiers when providing care, treatment and services.
- **NPSG 01.03.01:** Eliminate transfusion errors related to patient misidentification.
**Improve Communication**

**Goal 2:**
Improve the effectiveness of communication among caregivers.

NPSG.02.03.01: Report critical results of tests and diagnostic procedures on a timely basis.

**Medication Safety**

**Goal 3:**
Improve the safety of using medications.

NPSG.03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

NPSG.03.06.01: Maintain and communicate accurate patient medication information.
Clinical Alarm Safety

Goal 6:
Reduce the harm associated with clinical alarm systems.
NPSG.06.01.01: Improve the safety of clinical alarm systems.
- Leaders establish alarm safety as a hospital priority
- Identify the most important alarm signals
- Establish policies and procedures for managing alarms
- Clinically appropriate alarms
- When alarm signals can be disabled
- Who can set parameters, change parameters, turn off parameters
- Monitoring and responding to alarm signals
- Educate staff and LIP

Health Care-Associated Infections

Goal 7:
Reduce the risk of health care-associated infections.
NPSG.07.04.01: Implement evidence-based practices to prevent central line-associated bloodstream infections.
NPSG.07.03.01: Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.
NPSG.07.05.01: Implement evidence-based practices for preventing surgical site infections.
NPSG.07.06.01: Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTIs).
Reduce Falls

**Goal 9:**
Reduce the risk of patient harm resulting from falls.
NPSG.09.02.01: Reduce the risk of falls.

Pressure Ulcers

**Goal 14:**
Prevent health care-associated pressure ulcers (decubitus ulcers).
NPSG.14.01.01: Assess and periodically reassess each resident’s risk for developing a pressure ulcer and take action to address any identified risks.

Risk Assessment

**Goal 15:**
The organization identifies safety risks inherent in its patient population.
NPSG.15.01.01: Identify patients at risk for suicide. (Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.)
NPSG.15.02.01: Identify risks associated with home oxygen therapy, such as home fires. (Applicable to Home Care.)
Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™

- **UP.01.01.01**: Conduct a preprocedure verification process.
- **UP.01.02.01**: Mark the procedure site.
- **UP.01.03.01**: A time-out is performed before the procedure.

What is Your Role in Patient Safety??

- Engage and Educate the patient
- Speak up.
- Educate yourself.
- Adopt best practices.
- Model professional behavior.
- Eliminate intimidating behavior.
- Seek out safety issues.
- Hold each other accountable!
- When you see it, you own it.

Thank you!!