INSTITUTE FOR HEALTHCARE IMPROVEMENT

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SUMMARY REPORT: 90-DAY PROJECT

Top Ten Patient Safety Officer Challenges

October 31 2009

Executive Summary:

IHI has identified the need to produce a graduate course for patient safety officers (PSO). Nearly 1000 individuals have been trained by the IHI since 2004. The field of patient safety continues to evolve and IHI needs to continue to be a leader in this work.

This research investigated the needs of patient safety officers through a series of email questions that were sent to the IHI PSO list-serve, some phone interviews and a Webex meeting with a dozen PSO. Based on their responses, two lists of items were produced: a list of organizational issues such as implementation-execution, leadership, learning systems, etc. and a list of patient safety problems such as falls, pressure ulcers, diagnostic errors, etc. During this project a number of new potential faculty have been identified.

The list of ideas was then used to create a draft agenda for a PSO graduate update course. A new course could be presented each year. For example in 2010 you would have one course, but in 2011 you could present an essentially new course. The next steps are to identify a director for the work and recruit faculty. Marketing needs to be brought into the process soon to adequately inform PSO about this course.

I. Research and Development Team:

- Leader: John Whittington
- Colleague: Courtney Kaczmarsky

II. Intent:

The aim of this project is to identify the "top ten" patient safety officer problems and potential solutions to them. Based on this information an IHI PSO graduate course will be developed.

III. Background:

The IHI has been a leading force for patient safety for many years around the world. Since 2004 we have trained over 1000 patient safety officers (PSO). It is important for us to continue to know the challenges facing today's PSO in order for us to strengthen our safety work.

IV. Description of Work to Date:

Three main deliverables were identified for this work:

- Identification of the main problems that concern patient safety officers
- Solutions to those problems either through specific interventions or a general safety framework
- Outline for a potential course/ seminar based on this information

PSO identified issues of concern and through some iterative design a course was produced. This was started by asking the PSO through email what the major issues are that they face. They graciously responded with about 20 major organizational issues ranging from leadership to equipment that will be discussed more fully in the results section. These issues are now classified as organizational issues that PSO face. At the same time as we were receiving email input, a few telephone interviews were held with PSO.

We then showed this list of 20 top issues to the PSO and asked for volunteers through email who would like to be part of a 2.5 hour webex meeting to discuss safety issues in more depth. We ended up with the following individuals who attended the meeting:

Attendees

- Lillian Morris, lillian.morris@camc.org, Charleston Area Medical Center, Charleston WV
- Patricia McGillan, VP Patient Safety & Regulatory Compliance, Kindred Healthcare, Louisville, Ky
- Sandra McDonald, sandra.mcdonald@jax.ufl.edu, Shands Jacksonville, Jacksonville, Fl
- Katherine Jones kjonesj@unmc.edu University of Nebraska Medical Center
- Joe Halbach, halbachj@nychhc.org, Elmhurst Hospital Center, Elmhurst, NY
- Juanita Stroud, Juanita.Stroud@carolinas.org, Carolinas Medical Center, Charlotte, NC
- Kathy Haig, kathy.haig@osfhealthcare.org, OSF Healthcare System, Corporate Patient Safety Officer
- Donna Thatcher, donna.thatcher@providence.org, Providence Physician Division, Portland, OR
- Debbie Robins, robidc@shands.ufl.edu, Shands HealthCare Quality Management Department
- Mary Taylor, taylorma@wusm.wustl.edu, Washington University School of Medicine
- Theresa Manley, manleyt1@pamf.org, Palo Alto Medical Foundation

This meeting was organized around a series of questions and activities:

What do you need to do to move your organization to the next level of safety?
What is the current level of safety?
What tools did you use to answer the previous question? What do you need?
If you are not satisfied with where you are, what is your plan? What are you going to focus on?
How are you learning about progress on safety?
What is missing from the list of challenges that we created?

We also worked on creating a driver diagram or at least categorizing the big issues for safety.

An opportunity for sharing about work they were doing was provided.

Lastly we asked how IHI can help them. Please see Appendix A for a detailed summary of this meeting. Besides having a good discussion with PSO during this meeting, it also gave us a chance to look for potential new safety faculty.

Following the safety officer meeting on September 10th, this work was presented to IHI leadership at the research and development meeting on September 23. Feedback at the meeting showed that we still need to do more research on content topics that patient safety officers are working on: falls, pressure ulcers, diagnostic errors etc. Email was sent to PSO asking for ideas on major areas of content that they are dealing with. This led to another extensive list of ideas that the PSO shared with me. This list will also be discussed in the results section

V. Results of the 90-Day Scan:

The patient safety officers helped identify 20 major organizational topics. These were categorized into four large groups: Execution-Implementation, Learning System, Leadership Issues and Misc. issues. The details are listed below

Patient Safety Officer Organizational problems

Execution-Implementation

Sustainability

After a new process is introduced there is initial focus, but it is difficult to sustain it over time. Is there a limit to how much can be sustained?

New Practices

There are just so many changes to introduce and spread. Some of the changes are very complex.

System level thinking

More attention needs to be given to thinking about safety as a system property.

Learning System

Measurement

There is no proven gold standard for safety measures. How do we know that we are getting safer?

Reporting systems

Organizations have deployed safety-reporting systems with success. Lots of reports come in on a monthly basis. The success of reporting is now overwhelming their resources to manage the information.

Reporting and transparency

Concern was expressed about the need for more transparency within the organization to share significant issues.

Leadership Issues

Partial Success

There is just enough success that management doesn't feel compelled to work on organizational transformation to get after deep and fundamental issues.

Frontline staff
They need to be connected to the work of safety, see it as one of their key priorities. They need training for both teamwork and improving safety at the micro-system level. Frontline leadership also needs support and training for this type of work.

Sharing the work of safety
Safety needs to be seen as involving the organizations, doctors, management, front line staff and the PSO. The opposite is that safety is looked at as only a PSO responsibility.

Resources
Time, people and money are inadequate for the level of work that needs to be done. Some of the PSO have expressed just how much work is on their plate.

Reporting relationships
The PSO needs the right reporting relationship to be an effective member of the management team. The role needs to be seen as very credible. The relationship between quality, risk and safety need to be taken into consideration.

Prioritization of safety issues
There is a struggle on how to prioritize the work of safety. For example if you work in a large hospital you need to improve anticoagulation and insulin use. They are both important. Based on your previous track record you know it will take 12 to 18 months to truly transform practice and make it stick. How do you choose to work on one and not the other?

Miscellaneous

Doctor involvement
There is an important need to have doctors deeply involved in the work of safety.

RCA limitation
There is concern that root cause analysis (RCA) is swatting mosquitoes but not draining the swamp. Each RCA often solves a unique problem but doesn't get to the bigger issues.

Equipment
There are many issues around equipment and organizations struggle to manage them.

PSO Burnout
In view of the list above, burnout as a PSO is a real possibility.

Patient and family role in safety
What roles do patients and families have in safety?

Coordination of care
What are the safety issues that wrap around coordination of care?

After the above information was gathered another round of email created the following list of topics that could use help. Some of the ideas in this list have been basic safety issues that many have struggled with, for example pressure ulcers, falls, and medication safety. Others on the list are more advanced topics such as diagnostic errors.

Patient Safety Officer health care problems

Pressure Ulcers
Falls
Medication safety in general
- Anticoagulation
- Antibiotics including timeliness
- Insulin
- Bedside medication verification
- Medication reconciliation (across the care continuum)
- Programming critical drips and other harmful drugs on IV pumps
- Timely recording of allergies

Diagnostic Errors
Handoffs
- At discharge
- At transfer
- In general

Hospital Acquired infections
- Catheter associated urinary tract infections
- Hand hygiene
- Central line blood stream infections

Aspiration Pneumonia
Critical Lab values
Patient identification of chart pages, reports, lab specimens
Radiology Issues
- Radiology imaging and failure to diagnose correctly
- Preliminary readings are posted, BUT are not final. Final status readings can and many times do change, causing treatment plan to be out of date and in some cases, hazardous to the patient.
- Discrepancies between ED read versus Radiology final

Ilieus: prevention, identification, treatment
Conscious/Moderate sedation
Venous Thromboembolism
Acute care patients who are more vulnerable, namely people with learning disabilities.
Hyponatremia in children
Delays in care due to inpatient transport systems
Vaccination issues
'Bundle' for management of GI Bleeds
Implementation issues around the Electronic Medical Record and Clinician Order Entry
Perinatal Care particularly around births before 39 weeks

Faculty
A number of the PSO contributed to the development of this project and many of them appear to have potential to be faculty for the IHI. For an actual list of potential candidates, see the presentation that was given to IHI leadership on 10/20/09

VII. Conclusions and Recommendations:

Opportunity now exists to create a PSO graduate update course. This course could have new content every year. A draft agenda was created for a PSO graduate update course. (Appendix B) There is an abundance of topics that could be presented each year. The draft agenda was based on four ideas: work on organizational issues, discuss current patient safety health care problems, allow opportunity for sharing of new work that PSO are doing and create good opportunities to foster community for the PSO.

We should proceed with appointing a director for this work and identifying faculty. The course should start sometime in 2010.

VI. Open Questions:

VIII: Appendices:

A. Output from Virtual Meeting with PSO on September 10th 2009

Discussion

What do you need to do to move your organization to the next level of safety?

- Have been providing education to front line staff; administration believes that safety is a given, do not believe that it needs additional attention

- Need leadership to not depend on the efforts of a few-need to move it deeper into the organization so that safety is on everyone's agenda/responsibility and that it's not just a project
- Pt. Safety Values Aligned with administration/staff/physicians
- Sense-making for management-Management observes front line workers and sense-making for front line workers-Need to get people in a room together to understand complexities
- We don't integrate the language and process of change--too ad hoc. 2) because we have difficulty with that--it's too slow and reactive to get to the frontline--very similar to the current speaker's point
- We have to change the way people think….we need the language and thought process of learning organizations…Peter Senge The Fifth Discipline
- Patient safety is being driven from the top down - incorporated into strategic goals of the health system; expectations in every job description; transparency of quality/safety data has helped by sharing information throughout the organization
- Better sustainability through department level

What is the current level of safety?

- Struggling with this-working with Premier on 30 measures
- Do not have a good benchmark
- Understanding peoples perception of safety and how this informs staff and management
- Using Global Trigger tool as an internal marker
- Challenges in making sure that everyone is measuring in the same way- measuring whether they are stagnant or making improvement

What tools did you use to answer the previous question? What do you need?

- Outpatient tool pointed to areas of mistrust between management, physicians and their teams-clinic specific unusual occurrence reporting tool (quarterly basis)
- AHRQ instruments
- Transitions in care-looking to Eric Coleman
- Using HEDES measures

If you are not satisfied with the level of safety, what is your plan? What are you going to focus on?

- We're piloting our lab calling MET for specific critical values to increase rapid response in addition to calling to the unit
- We have an inventory tool that we use to determine if an organization has appropriate practices in place to support all 4 key components of a culture of safety: reporting, just culture, teamwork, and learning cultures.
- Have a strategic quality improvement plan but still needs to be process and data driven in the smaller hospitals-need to build the capability
- Creating positive response/situation; something that will show that staff is engaged and willing to learn-developing a safety coach physician at each local clinic level and training front line staff in basic safety tools
- improving RCAs to achieve organizational sense-making not event sense-making
- We developed a 5 step plan to address serious adverse events-would be happy to share-Kathy Haig

How are you learning about progress on safety?

- IHI, TJC, NQF, AHRQ and staff feedback
- We're moving forward with implementing Team STEPPS, just culture with HR, LifeWings in surgery and cath lab
- IHI; University Health Consortium; CDC; professional organizations - ACC, ACOS, etc.

Patient Safety Challenges List

Are there items that are missing from the list?

- Advancing the patient safety officer learning and training
- Communication tools for PSO's to translate where the organization is in its progress
- Patient Safety Infrastructure- team work culture, reporting culture, learning culture, just culture; will then lead to improvement at the topic level
- great list - competing priorities is a challenge

Can we make these ideas more safety specific?

- Addressing serious adverse events that happen somewhere in the system; how do you deal with a report. Creating a learning system.
- Root cause analysis
- Corrective action plan and measurement
- Implementation of corrective action plan; reporting.
- Structure, process, outcome framework
- Consumer education-creating the accountability, demanding a change.
- Implementing EMR-do not have balancing measures in place to help staff
- How do you keep safety from seeming like a project with a beginning and an end
- How to identify at risk behaviors and how to mentor staff
- Organizational learning from cases that go to peer reviewed committee
- 'Just Culture'...great opportunity to apply structure-process-outcome framework
- How can you safely talk about peer review activity-what can you share
- Structure is training in use of an Algorithm to determine at risk behavior, process is monitoring actual use of the algorithm, outcomes would include measurement of the Nonpunitive Response to Error dimension on the AHRQ Safety Cutlure Survey
- We have a large number of Residents and their knowledge on patient safety coming in is limited. We piloted providing a pt safety class in July along with an orientation fair where they had to find answers to safety/procedure/quality questions and it was well received. Past residents commented they would have liked to receive the same info.
- We have developed a core curriculum that all physicians will take, actually across the medical school, resident, faculty continuum, and then when specific issues or events occur, we focus on specific safety issues. We are actually in the development of a Medical School Safety Structure and have flowcharts, diagrams and many templates we are piloting. We already have standard PS education using local case examples for housestaff and faculty.
- Physician engagement - I think we are making strides---but strides that challenge the hospitals safety status quo.
- Recently appointed Physician Directors of Quality (PDQ's) for each department. Their role is being defined to serve as the dept expert on quality and patient safety.

- The VA's National Patient Safety Center has an extensive curriculum for staff and physicians that is available to everyone on their website. http://www.patientsafety.gov/

Driver Diagram

The longer list is what is inhibiting us from patient safety. What are the big ideas?

- Reporting and transparency
- System level thinking, resources, doctor involvement, mangement involvement
- Sharing the work of safety due to peer review
- Lack of physician engagement 2. Lack of funding/respect for PS as a medical specialty 3. Failure to share lessons learned across physician departments 4. Liability climate and fear looms large, still and inhibits transparency
- learning system, frontline staff, system level thinking, resources, management involvement
- lack of top level engagement, doctor involvement, lack of systems thinking
- sustainability, System Level Thinking, Physician Involvement, Learning System
- Resources, frontline staff, sharing the work of safety
- Physician involvement; resources; learning system; transparency
- Lack of a sense of urgency 2. Fixation on events and not systems 3. Lack of knowledge of basic patient safety principles 4. poor understanding of how to operationalize just culture
- Frontline staff, resources (content and spread), prioritization

Are you trying anything really different? What are some areas of success and how are you able to achieve them?

- Focused efforts on frontline staff to empower-emphasized open and safe culture
- Changed the way events are reported-developed a small intake session; one person presents to a small group. Dealing with how people talk about events.
- Language on the micro level--if you can't have a crucial conversation that is "safe" (non-threatening")-they can
- We are making progress in using TeamSTEPPS tools to support the other three components of safety culture. We have trained 35 of our 65 Critical Access Hospitals in TeamSTEPPS.
- Sharing information that comes out of root cause analysis
- Take care of the patient; take care of the clinician and then move on to prevention. Must have really professional resources to process this emotional component.

- Developing an advanced training for physician coaches who will coach for disclosure and support clinicians involved in events. We're working with several other centers around the country to develop/steal ideas that will work here in our culture.
- We have several Quality and Safety Operational Councils (QSOCs). Each facility is represented. It is a time to discuss and share best practices, prepare for regulatory requirements, etc. We also use this venue for education. If one of the reps attends a conference, they will provide a presentation to share the education. The System quality/ safety indicators are reviewed and discussed.
- Monthly PSO conference call-one facility shared an event and walked through their process
- We are also working with Risk Management to determine if the concerns that are reported to our risk carrier have also been identified/addressed as a safety concern.
- Include skills in effective RCA facilitation is an essential PSO skill….focus on using events for organizational sense-making
- Leap frog resources, surveys on a shared site
- Our risk management, quality and patient safety services are combined into a single corporate department. As a result, we mine the data in the incident report (patient safety report) database as we would any other database throughout each facility in the system to identify trends and develop improvement plans. This also helps prioritize as we can focus on improving processes that will have the greatest impact on improving patient outcomes.

How can IHI Help You?

- How to find ways to pay for the work that you are doing-assistance with writing & securing grants, etc.
- At the PSO Training course could talk about it more from the medical school and faculty perspective, less from the physician perspective.
- How to connect with PSOs when working in ambulatory care?
- How do we interface with the new Patient Safety Organizations in our states?
- This issue of RM and PS coordination is still a troublesome one. We are interested in real-time claim reviews for lessons learned--instead of always waiting for closed claim reviews.
- Right now we are not partnering with the state PSO. We are still looking at conflicting statutes at the state level that may impact the federal protections.
- Using the Global Trigger Tool for more than presenting reports to the board; how can you use it for more?

- What is the best way to present the data and stories in general to multiple audiences?
- Help with sending the message of the importance of patient safety.

B. PSO Graduate Update Course Agenda

DRAFT AGENDA

Day One:

7:30 – 8:30 AM **Registration and Continental Breakfast**

8:30 – 8:45 AM **Welcome and Introductions**

8:45 – 10:00AM **Running a safety program: lessons from the front**

During this session we want to examine the key ingredient in a high performing safety system. We will use examples from international work along with great programs in the US.

10:00– 10:15 AM **Break**

10:15– 11:15 AM **Helping Physicians lead safety work**

This session will discuss how to help physicians lead safety work with their peers.

11:15 – 12:15 PM **Diagnostic Errors, what do we know?**

This session will highlight some of the issues around diagnostic errors and some promising strategies.

12:00 – 1:00 PM **Lunch**

1:00 – 3:00 PM **Translating high reliability principles into behaviors that you can use on a day to day basis**

This session will focus on organizations that have used a set of behaviors to transform them to high reliability organizations over the course of two years.

3:00 – 3:15 PM **Break**

3:15 – 4:15 **Breakout session: Falls, Medication safety and Pressure Ulcers**

Participants will have the opportunity to go to one of three breakout sessions. Faculty to be determined.

4:15 – 5:00 PM **Three good ideas that you have shared with us**

During this session we will have three short presentations from work that patient safety officers would like to share with us.

5:00 – 6:30 PM **Networking Cocktail Reception**

Day Two:

8:00 – 8:45 AM **Introducing and sustaining new practices**

Participants will have a chance to discuss issues around the complexity of new practices, what makes for successful introduction and how to make them stick.

8:45 – 9:45 PM **How great leaders lead the work of safety**

Retired Admiral X(I have the person in mind for this) will explain how he took a low performing nuclear aircraft carrier to a state of safety that defined the concept of high reliability.

9:45 – 10:00 AM **Break**

10:00 – 11:00 AM **Developing your learning system**

Participants will understand the keys to a great learning system for safety and the limits in our present system. There will be discussion around system level measures, FMEA, RCA, near miss and incident reporting.

11:00 – 11:45 AM **New ideas around handoffs**
Participant will discuss what constitutes an effective handoff and why this does not occur. Specific risk areas will be discussed such as transfers and discharges.

11:45 – 12:00 PM **Summary**

12:00 – 1:00 PM **Lunch**