HEALTHTECH S3
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CLINICAL CONNECTION

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PATIENT SAFETY AWARENESS WEEK
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TIME TO CELEBRATE OR IS THERE MORE WORK TO DO?

This week, there has been greater emphasis on patient safety by some of the leading organizations such as IHI, AHA, Lucien Leape Institute, AHRQ, and their partners. The data published at the end of 2017 suggest that health care organizations have made some improvement in patient safety. While reviewing the numerous websites and articles, most suggesting that patient safety should be a #1 priority, this writer reflected on personal experiences in boardrooms, hospital agendas, and where patient safety falls. As a reader, please answer that question for yourself; is patient safety #1 on all of your agendas?

The Agency of Healthcare Research and Quality (AHRQ) defines a safety culture as "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." Since this writer is a simple person, the summary of the qualities in the definition seems to describe the central them of trust; trust from the top down and bottom up. Safety must be about actions and processes that are embedded in the fabric of the organization and the people who make up the organization.

According to Leapfrog data, "Many hospitals in this country have safety records that wouldn't be tolerated in any other industry. The statistics can be thought-provoking and alarming:

- As many as 440,000 people die every year from hospital errors, injuries, accidents, and infections.
- Every year, 1 out of every 25 patients develops an infection while in the hospital—an infection that didn't have to happen.
- A Medicare patient has a 1 in 4 chance of experiencing injury, harm, or death when admitted to a hospital.
- Today alone, more than 1000 people will die because of a preventable hospital error."[1]

Some will say that errors are inevitable because humans are involved and we make mistakes. Others might build upon that rationalization and say that we have put in place measures that hopefully will prevent serious injuries, however based on the above data, would you or a loved one be okay with being one of the statistics? Would other industries like the airlines and automotive survive with such statistics; probably not.

The health care environment is ripe for errors since those of us who work in hospitals, clinics, and physician practices become desensitized to our surroundings, and are not always alert to the potential signs of an imminent mistake. Here's a real life example, many of us take the same route to work each day simply because it's the most direct route and perhaps less trafficked. We are aware of the stop signs, traffic lights, curves in the road, and the best time to beat the traffic, right? One day the civil engineers have decided to shorten the timing for one of the traffic lights, and the light changes as you are trying to make it through the light. The next event happens so quickly that you don't even realize that a car has struck you. And why did that happen? You ran the light. Innocent mistake on your part? Or is it the civil engineer's fault because of the change? Where should the blame fall or should there be any blame at all?

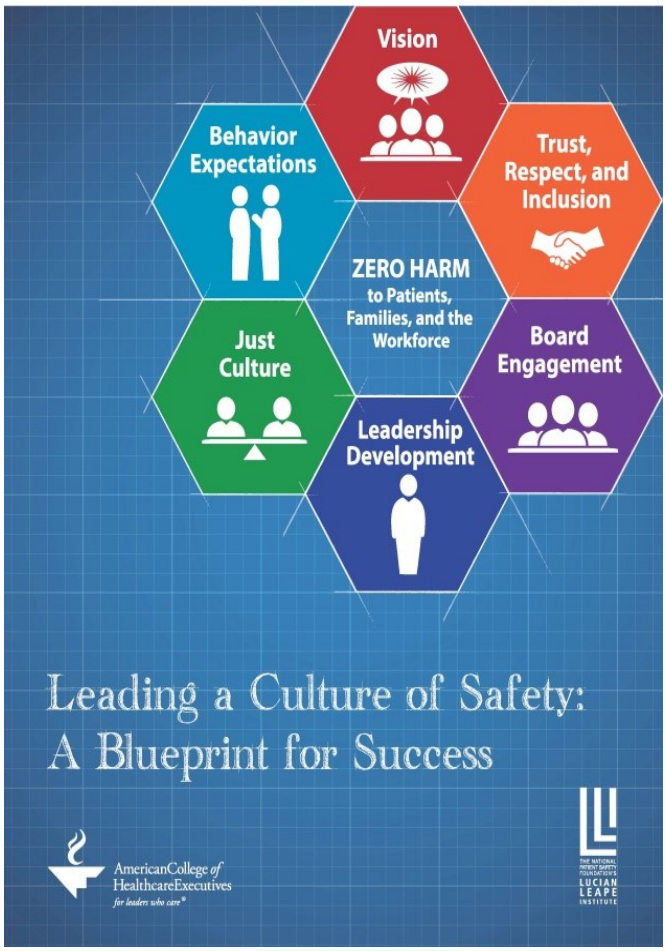
Think about the medical errors the media has reported of instruments left in a patient's body during surgery (but we did do the count) or the nurse who administers the wrong dose of medication to a child resulting in the death of the child. The nurse is fired, can't find a job and subsequently commits suicide (true case).

Another travesty that impacts patients and cost is unnecessary medical care. IHI reports that the Washington Health Alliance reported that in the state of Washington, unnecessary medical care for one year affected more than 600,000 patients with an estimated cost of $282 million.[2]

Amelioration Strategies

The good news is that there has been some improvement, however there is opportunity for further improvement in order for health care to report that it is a safe industry. In 2015, the National Patient Safety Foundation (NPSF) provided eight recommendations to help mitigate medical errors.

1. Ensure that leaders establish and sustain a safety culture
2. Create centralized and coordinated oversight of patient safety
3. Create a common set of safety metrics that reflect meaningful outcomes
4. Increase funding for research in patient safety and implementation science
5. Address safety across the entire care continuum
6. Support the health care workforce
7. Partner with patients and families for the safest care
8. Ensure that technology is safe and optimized to improve patient safety[3]



Source: npsf.org

NPSF has provided an infographic that depicts the "road to zero harm" in health care organizations. Do note the title of the infographic, Leading *a Culture of Safety: A Blueprint for Success*. Clearly, the CEO and board are responsible for the safety of those entrusted into our care, however the culture of safety rests with all who provide care.

Making It Happen

Health care organizations, big or small, urban or rural, are complex entities made up of a myriad of titles, responsibilities, regulations, history, culture, personalities and most important, people! People who want to do what's right for those who seek our services. So how can we assure that patient safety is a priority? Some thoughts…and perhaps a checklist.

THOUGHT	YES	NO	MAYBE
The CEO becomes the lead for patient safety			
A review of the vision statement is done to assure that safety for patients and staff is included			
A Medical Staff champion volunteers to make patient safety a priority with providers			
Every meeting begins with a success story about patient safety			
Safety is the #1 agenda item at every board meeting			
Board members are active in assuring patient safety by attending patient rounds			
A just culture plan is developed by senior leaders and middle managers			
Patients are always included in managing their own care			
Patient safety is integrated into the patient experience			
Errors are preempted by encouraging any and all people to speak up regardless of title			
Transparency is #1 when reporting near misses and errors			
Expectations about patient and employee safety are clearly defined			
Review processes and identify barriers to accomplishing the processes safely			
Identify workarounds and openly discuss how they may compromise safety			
Initiate meaningful safety huddles, e.g. review of the past 24 hours, staffing, potential for errors, near misses. Congratulate those who made a difference in keeping others safe.			
Focus on improving one safety issue for 30 days, e.g. ED safety			
Identify behaviors that encourage trust and effective communication			
Learn from other industries that have significantly improved safety			

Think about your brand and how you can include safety, with the intent that your words are actionable and not reactionable.

"SAFETY FIRST" IS
"SAFETY ALWAYS."

CHARLES MELVILLE HAYS

[1]Leapfrog. 2017
[2] IHI. The cost of unnecessary care.
[3]NPSF. Free From Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human

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