EMBRACING AND LEARNING FROM ERRORS

BY

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OBJECTIVES

• PARTICIPANTS WILL BE ABLE TO:

1. PROMOTE PATIENT SAFETY CULTURE - QUALITY AND SAFE CARE.
2. APPLY SAFETY CULTURE CONCEPTS TO DRIVE QUALITY IN HEALTH CARE DELIVERY VIA NON-PUNITIVE ENVIRONMENT
3. UTILIZE MEANINGFUL APPLICATION OF NATIONAL AND AGENCY QUALITY IMPROVEMENT INITIATIVES TO ADVANCE BEST PRACTICES.
4. IMPLEMENT EFFECTIVE IMPROVEMENT TOOLS TO ENHANCE SAFE PATIENT CARE IN ALIGNMENT WITH APPLICABLE ACCREDITING BODY OR CERTIFICATION REQUIREMENTS.
HUMAN ERROR

THE SINGLE GREATEST IMPEDIMENT TO ERROR PREVENTION IN THE MEDICAL INDUSTRY IS

“THAT WE PUNISH PEOPLE FOR MAKING MISTAKES.”

DR. LUCIAN LEAPE

PROFESSOR, HARVARD SCHOOL OF PUBLIC HEALTH

TESTIMONY BEFORE CONGRESS ON HEALTH CARE QUALITY IMPROVEMENT.
PATIENT SAFETY

• ACCORDING TO THE WORLD HEALTH ORGANIZATION, “PATIENT SAFETY IS A SERIOUS GLOBAL PUBLIC HEALTH ISSUE. ESTIMATES SHOW THAT IN DEVELOPED COUNTRIES AS MANY AS ONE IN 10 PATIENTS IS HARMED WHILE RECEIVING HOSPITAL CARE. OF EVERY HUNDRED HOSPITALIZED PATIENTS AT ANY GIVEN TIME, 7 IN DEVELOPED AND 10 IN DEVELOPING COUNTRIES WILL ACQUIRE HEALTH CARE ASSOCIATED INFECTIONS.
CULTURE OF SAFETY

• IMPROVE PATIENT OUTCOMES BY REDUCING PATIENT HARM

• REDUCE PREVENTABLE HARM THROUGH ERROR PREVENTION A MAJOR STRATEGIC OBJECTIVE
BY ASSESSING ERRORS IN PATIENT SAFETY CULTURE
  • IDENTIFY DATA TO COLLECT, ASSESS FOR TRENDS, AND MEASURE PATIENT SAFETY IMPROVEMENTS
    BY TRACKING ERRORS AND THE EFFECTIVENESS OF CORRECTIVE MEASURES

• STRIVE FOR A NON PUNITIVE ENVIRONMENT WHERE STAFF ARE ABLE TO REPORT ERRORS OR
NEAR MISSES WITHOUT FEAR OF REPRIMAND OR PUNISHMENT IN ORDER TO “LEARN FROM
OUR MISTAKES”.

• THIS IS AN OLD CONCEPT WHICH IS A GROWING PARADIGM SHIFT IN THE HEALTH FIELD
CULTURE OF SAFETY

• ACHIEVE A CULTURE OF SAFETY THROUGH LEADERSHIP SUPPORT
  • LEADERSHIP RECOGNIZES PATIENT SAFETY AND MAKES IT A TOP PRIORITY BY ACKNOWLEDGING HIGH RISK NATURE OF ACTIVITIES IN HEALTH FIELD

• ENCOURAGE COLLABORATIVE MULTIDISCIPLINARY REVIEW

• DESIGN AN ENVIRONMENT TO BE LESS ERROR PRONE AND MORE HUMAN ERROR TOLERANT

• FAIR AND EQUITABLE ACCOUNTABILITY - EMPLOYEES AND LEADERSHIP ARE ACCOUNTABLE
CONCEPTS

• UNINTENTIONAL HUMAN ERROR
  • COMPETENCE, PERFORMANCE,

• UNINTENTIONAL & UNPREDICTABLE
  • CAREGIVER INVESTIGATE AND TEACH OTHERS

• UNINTENTIONAL RISKY ACTION / BEHAVIOR
  • CAREGIVER SHOULD RECEIVE COACHING
CONCEPTS

• INTENTIONAL ERROR
  • CONDUCT, ADDRESS IMMEDIATELY

• INTENTIONAL RISKY BEHAVIOR
  • “RECKLESS” ACTION / BEHAVIOR – RETRAIN CAREGIVER
CONCEPTS

• MALICIOUS ACTION
  • SUSPEND DUTIES

• IMPAIRED JUDGEMENT / IMPAIRED THINKING
  • DISCIPLINE IS WARRANTED
SYSTEMS APPROACH TO CORRECTING ERRORS

• ADDRESS WEAKNESS IN THE SYSTEM

• STEPS TO BE TAKEN BY ALL
  • TRANSPARENCY
  • STANDARDIZATION OF PROCESS
  • COMMON LANGUAGE SO ALL ARE AWARE
  • CLEAR EXPECTATIONS
EXAMPLES OF IMPROVEMENT

- Medication Errors
- Mislabeled Specimens
- Critical Value Notification
- Patient Falls
- Adverse Drug Events
- Reduced Readmissions
- Improve MDT Hand Hygiene
- Reduced Catheter Acquired UTIs

- Use Webcident to address Med Errors, Mislabeled Specimens, Patient Falls
- A3 Reports to monitor Critical Value Notification, Adverse Drug Events, Readmissions, Hand Hygiene, Hospital Acquired Infections
SYSTEMS APPROACH

• STANDARDIZATION OF:
  • TRAINING, COMPETENCIES,

• TIMELINES, EXPECTATIONS ARE CLEAR

• QUALITY IMPROVEMENT INITIATIVES
  • PARTNERSHIP FOR PATIENTS (IHS)
  • NO PLACE LIKE HOME (AZ)

• RISK MANAGEMENT REVIEW TEAM
  • USE OF WEBCIDENT AS A MONITORING TOOL
EFFECTIVE IMPROVEMENT TOOLS

PDSAS
TESTS OF CHANGE
INTENTIONAL ROUNDEDG
DATA MONITORING
FAILURE MODE EFFECT & ANALYSIS (FMEA)
ROOT CAUSE ANALYSIS (RCA)
CURRENT PROJECTS

- ADDRESSING HIGH RATE OF LWOBS
  - FAST TRACK IN THE EMERGENCY DEPARTMENT
  - PROVIDER IN TRIAGE (PIT) IN THE EMERGENCY DEPARTMENT
- STAFFING SHORTAGES IN SPECIALTY AREAS
  - CROSS TRAINING
  - GROW OUR OWN
  - LOOKING AT A NATIONAL FLOAT POOL CONCEPT
  - LOOKING AT INTRA-AREA FLOAT POOL
- INTERAGENCY REFERRAL PROCESS
- STRATEGIC SUCCESSION PLANNING
QUESTIONS?