



Linking Quality and Patient Safety

Subtopic III



Linking Quality and Patient Safety

Learning Objectives

The learner will understand

- how a focus on quality will improve patient safety
- the human and system factors that contribute to error
- the shift in thinking related to approaches to patient safety
- the transition to a “just culture”
- the critical importance of engaging patients and families
- the importance of transparency and the healing factors associated with disclosure



The Patient Safety Movement

A Shift in Thinking

Evidence-Based Change

To Err is Human: building a safer health system (1999)

- Institute of Medicine's (IoM) report
 - 98,000 deaths/yr in U.S. related to medical error
 - Top 10 causes of death

The Canadian Adverse Events Study (Baker and Norton, 2004)

- one in 13 patients in hospitals experiences an adverse event.
- Of 185,000 adverse events 70,000 were preventable

Canadian Institute for Health Information, Canadian Patient Safety Institute

Measuring Patient Harm in Canadian Hospitals. With What can be done to improve patient safety? authored by Chan B, Cochrane D. Ottawa, ON: CIHI; 2016



Linking Quality and Patient Safety

Health care is complex and involves human interaction leading to increased risks for error

Many reasons account for error, including

- communication breakdowns (handover)
- poor team collaboration
- fatigue
- workload
- multiple distractions and interruptions
- complexity of processes
- reliance on memory
- limited orientation and transitions to new roles
- staffing models

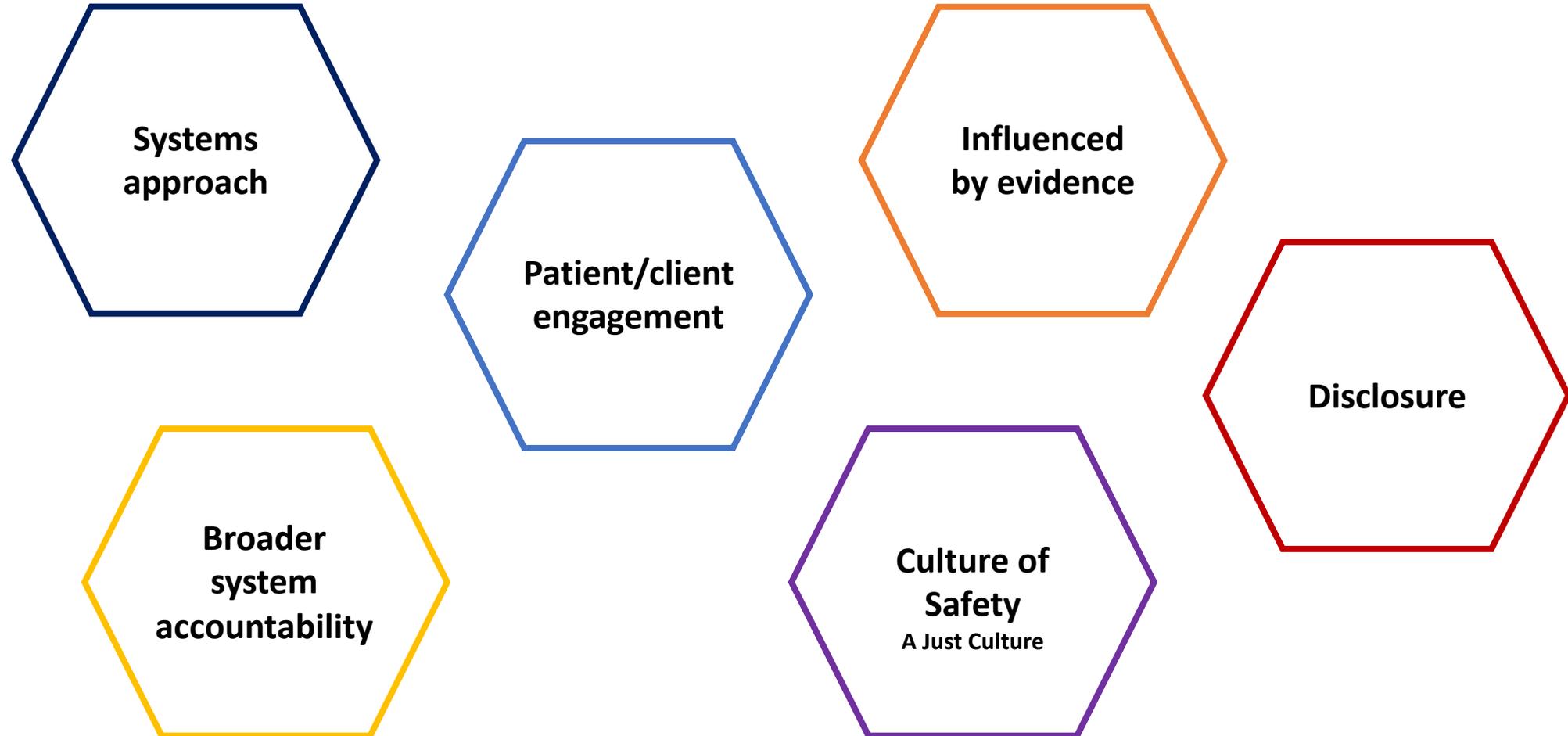
There is a growing movement to change the systems and root causes that result in error, rather than focusing on personal blame

Not who blundered but how and why the defenses failed.



The Patient Safety Movement

A Shift in Thinking





The Patient Safety Movement

A Shift in Thinking

Evidence-Based Change

Key Recommendations:

Engage care providers
and listen to the
experience of patients
and their families

Engage individuals and
groups to use the data
to improve safety

Identify specific
improvement
strategies to address
contributing factors

Prioritize a quality
improvement topic

Create quality
improvement teams

Be transparent

Establish specific goals

Review and provide
recognition

Make monitoring
patient safety an
organizational priority



The Patient Safety Movement

A Shift in Thinking

Evidence-Based Change

Summary:

- costs of unsafe care demonstrate the critical importance of continuing to improve safety
- there have been large improvements in how patient safety incidents are approached
- the tradition of blaming and shaming in response to error has shifted to a culture of openness and learning
- leaders have come to understand the importance of keeping a constant focus on safety
- measuring, reporting, learning and improving after patient safety events is becoming the norm,
- there is still a long way to go.
 - Harm is experienced by patients in 1 of every 18 hospitalizations
 - About 20% of patients experience more than 1 occurrence of harm.



Responses to Error

- There are two philosophies:

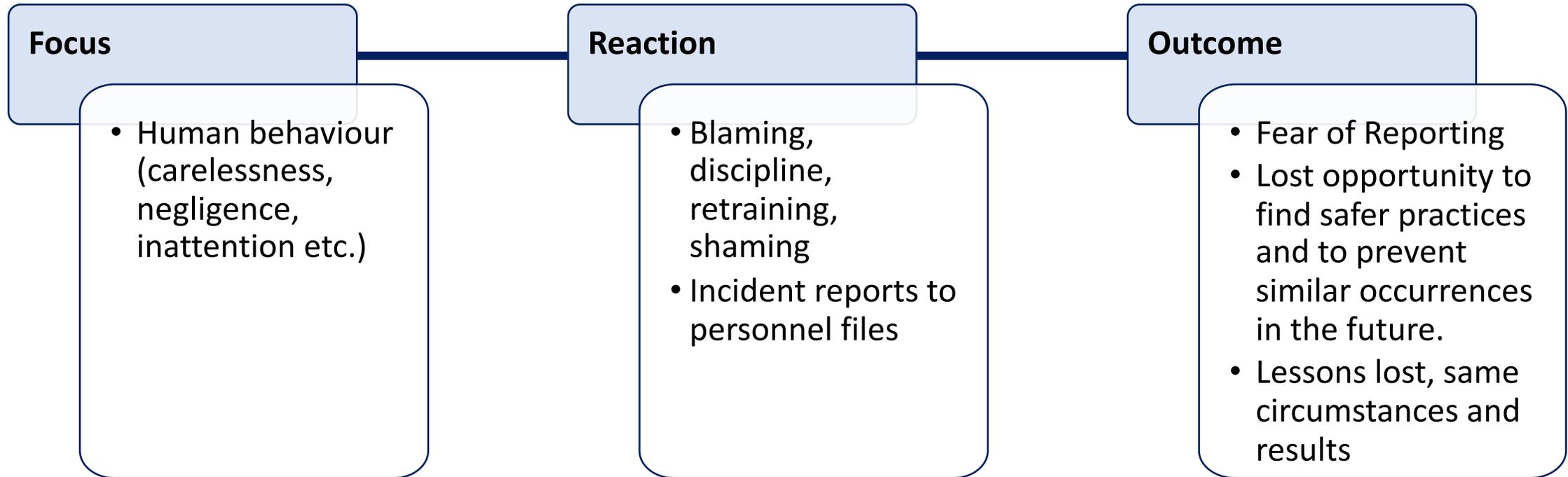
**The Person
Approach**

**The System
Approach**



Responses to Error

“The Person Approach”





Responses to Error

The Person Approach

Early in my career, I was a staff nurse in a critical care unit (CCU). We were required to rotate to the PACU (post anesthesia care unit) every few months.

During my first rotation through the PACU, I was assigned to the evening shift and along with another nursing colleague was assigned to a “bay” that was able to accommodate six patients post-operatively. Two patients who were more complex than anticipated were admitted and for a few hours we were very busy responding to their care needs.

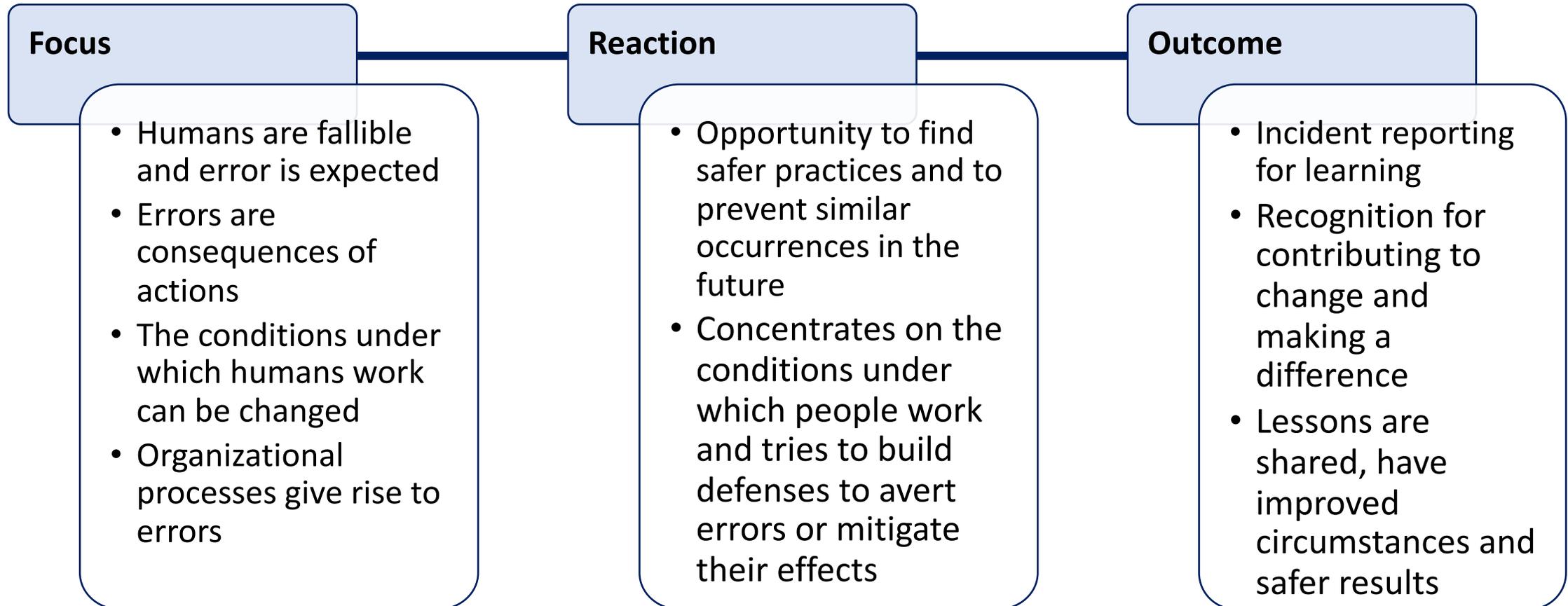
The next evening when I arrived for my shift I was asked to meet with both the manager of the PACU and the CCU. They informed me that the evening before I had erred in administering an antibiotic to a patient when it was not ordered.

They noted that this error would be documented in my file and that there would be consequences if there were repeated mistakes in the future.



Responses to Error

“The Systems Approach”





Responses to Error

The System Approach

Later in my career I held the position of Nursing Director, responsible for a number of medical units. One day I was informed of a serious error that had contributed to a patient's death the night before. The patient had gone into pulmonary edema and a bolus of Lasix was ordered. The nurse, mistakenly drew up valium instead, this was administered by the physician (a first year resident) and the patient had a cardiac arrest and died. A number of system issues contributed to this error. This was an emergency situation and there was a sense of urgency. The unit only had small ampules of Lasix so a number were required to obtain the dose ordered. The ampules were brown in colour, as were the ampules of valium; also the same size. The ampules were stored close to each other and the nurse and resident missed the required checks prior to administering the drug.



The Patient Safety Movement

A Shift in Thinking

A Just Culture

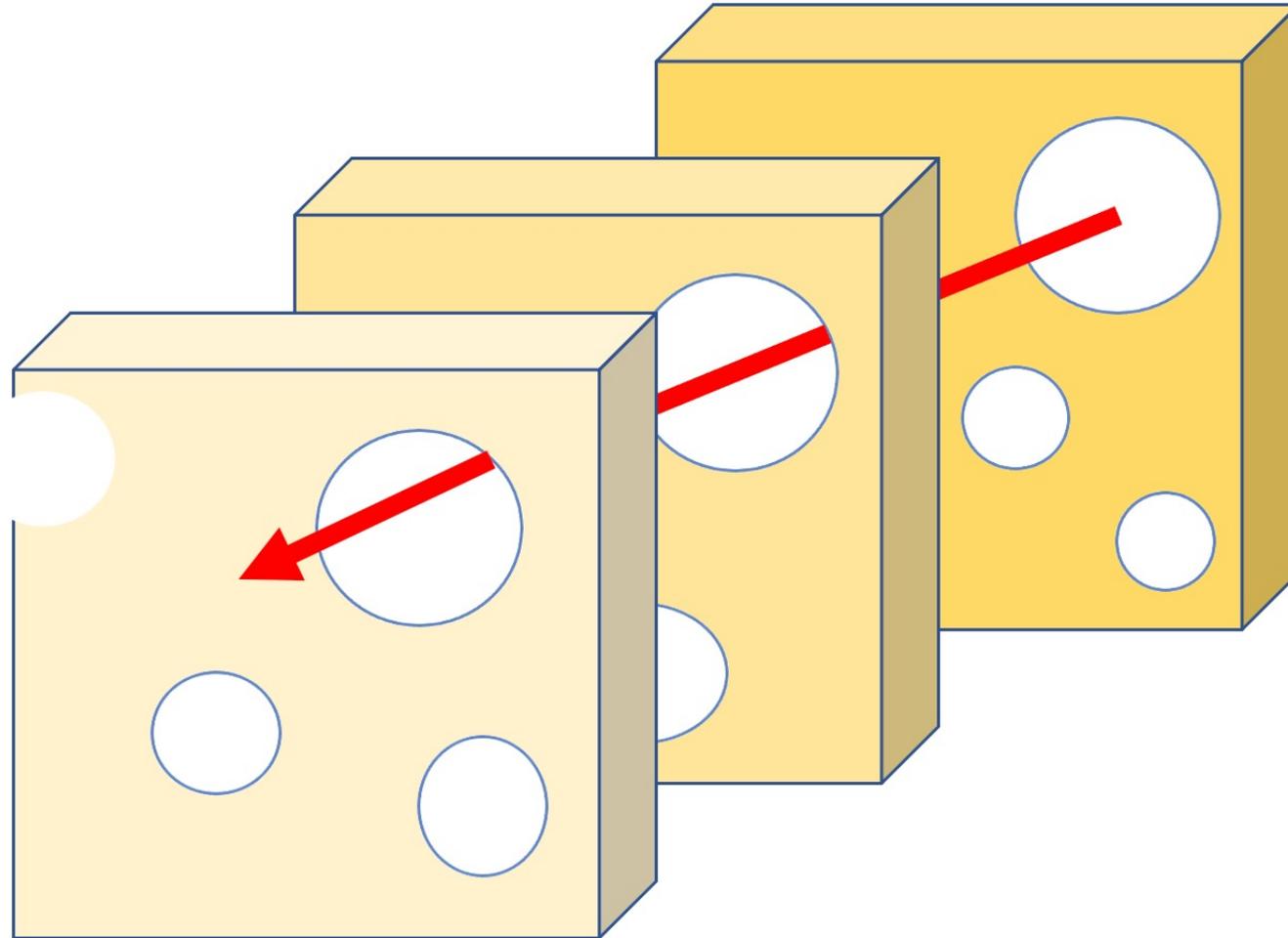
Summary

- There is recognition that system failures and poor processes contribute to error
- Outcomes are influenced by structures (staffing, physical environment) and processes
- Leadership is an integral part of ensuring a just culture of safety, whereby
 - There is support for team collaboration and innovation
 - Adverse events and near misses are openly reported and communicated
 - People are held accountable and recognized for reporting therefore enabling improvement opportunities
 - the focus is on learning from mistakes
 - analysis of the root cause of the error
<https://www.bing.com/videos/search?q=youtube+root+cause+analysis>
 - an error is an opportunity for change



James Reason's Swiss Cheese Model

A System's Approach





James Reason's Swiss Cheese Model

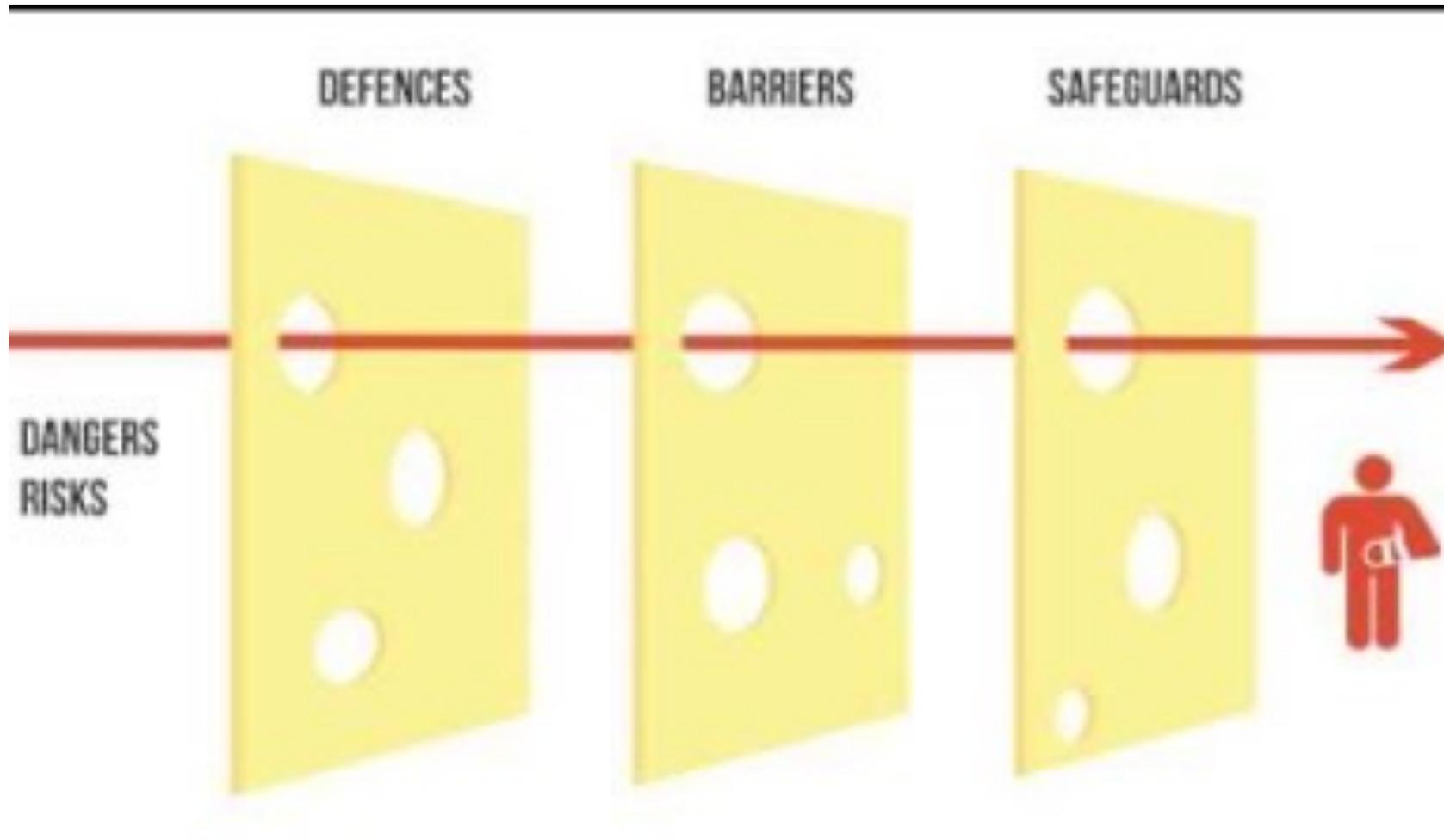
A System's Approach

Reason designed this model based on the following assumptions:

- Care consists of connected processes that influence each other, and patient outcomes.
- If a misstep occurs in one of these processes it may be identified, recognized
- An intervention at this might prevent harm or a negative result
- In a series of connected processes there are safeguards in place to prevent failure.
- The model assumes that every single safeguard itself is not perfect and can be penetrated because of latent conditions or active failures.
- Putting barriers in place at every step of a process makes it more difficult for an error to occur.

When an error does occur then it is likely that the holes line up.

This Video Which Provides a Summary of the Model *“Reason’s Swiss Cheese Model”*



<https://www.youtube.com/watch?v=MfWpMrEOIj8>

This Video Illustrates Reason's Swiss Cheese Model With A
COVID 19 Example
"Stop the Spread"



<https://www.youtube.com/watch?v=kyq1YedOLtY>



Engagement of Patients and Families

“nothing about me without me”

- Listening to families who know their family member best
- Focus on patient/person and family centred care (ECFAA)
- Patient stories
- Patient/Family Advisory Committees
- Engagement in the development of performance improvement plans
- Membership of key committees (Quality Committee of the Board)
- System-wide Advisory groups (HQO)
- Accreditation Canada
 - Standards
 - Patient surveyors

<https://www.psqh.com/analysis/patient-engagement-in-patient-safety-barriers-and-facilitators/>



Engagement of Patients and Families

Patients for Patient Safety Canada



https://www.youtube.com/watch?v=JB1Us_B5vhM



Disclosure

- The process by which health care professionals communicate adverse events to patients or families
- Disclosure of errors
 - acknowledges the right of patients and families to be informed
 - facilitates the healing process of all concerned
 - needs to be open and transparent (Keatings et al., 2006)
- Legislation regarding reporting and disclosure exists across the country. (ECFAA)

Huddles as a Strategy for QI and Patient Safety



Subtopic IV

- Brief inter-professional meetings
- Focus on patient safety/quality of care
- Often at the beginning of shift
- Less than 15 minutes
- Attention to concerns that have been identified or anticipated
- Also used as an organizational tool to identify improvement initiatives



Summary

- a focus on quality will improve patient safety
- humans are fallible, therefore error should be expected and safeguards and system improvements should be put in place
- the shift in thinking related error safety has transitioned to a “just culture”
- it is critical to engage patients and families across the system, to improve quality and to ensure safety
- transparency and disclosure is the right thing to do.