

## **Issue Strategy Group - Patient Safety**

### **Introduction**

Health care as it exists today in America, is one of the safest health care systems in the world, but it could be safer. The Institute of Medicine, in its report “To Err is Human, Building a Safer Health Care System,” estimated that between 44,000 and 98,000 individuals die each year as a result of medical error. The Institute of Medicine, as well as the general public, has challenged health care providers to provide safer care.

In the follow-up report, “Crossing the Quality Chasm,” the Institute of Medicine identified six key dimensions in which today’s health care system can operate at improved levels:

1. Safety - avoiding injuries to patients from the care that is intended to help them;
2. Effectiveness - providing services based on scientific knowledge and refraining from providing services to those not likely to benefit;
3. Patient centeredness - providing care that is respectful of and responsive to individual patient preferences and values;
4. Timeliness - reducing waits and sometimes harmful delays for both those who receive and those who give care;
5. Efficiency - avoiding waste, including waste of equipment, supplies, ideas and energy; and
6. Equality - providing care that does not vary in quality because of personal characteristics.

To respond to this challenge, the Nebraska Hospital Association, the Nebraska Medical Association and the Nebraska Pharmacists Association joined together and sponsored their first regional conference, “Improving Patient Safety in Nebraska,” in April 2001. This meeting was well attended and there was great enthusiasm among the participants for continued efforts to improve the safety of health care delivery in Nebraska’s hospitals. In June 2001, the Nebraska Hospital Association developed a policy brief outlining the need for continued emphasis in this area. The NHA shared the policy brief with the Nebraska Medical Association and the Nebraska Pharmacists Association, and all three associations took the issue to their respective Boards. All three organizations agreed to create and participate in an Issue Strategy Group on Patient Safety. The purpose of the Issue Strategy Group is to develop a plan for Nebraska health care providers that will:

- foster the sharing of knowledge and information about optimal patient safety practices and models;
- convene stakeholders for an ongoing dialogue in support of patient safety improvements; and
- encourage individual health care providers to identify causes and influence changes in their health care delivery systems to prevent medical errors.

The Issue Strategy Group (ISG) on Patient Safety held its organizational meeting on September 19, 2001. It is the basic premise of the ISG that the incidence of medical errors can and should

be reduced, not by blaming an individual, but rather by establishing an organizational culture that strives to reduce the potential for errors; where information is shared voluntarily by all health care providers, without fear of discovery; and where professional societies and organizations work hand-in-hand with the health care systems to protect the patients we serve through education and training.

The members of the ISG identified five central themes around which work groups were developed. These themes are as follows:

1. reporting issues;
2. cultural issues;
3. how to break down barriers for sharing information/challenges to sharing information;
4. confidentiality of information shared/legislative issues; and
5. funding issues

## The issue of ‘Culture’

- *We must migrate away from a culture of ‘shame and blame’;*
- *We must migrate to a culture of ‘system improvement’;*
- *Individuals must be rewarded for reporting adverse events and near misses;*
- *All employees share equally in the responsibility to identify and share patient safety information;*
- *We must encourage the use of national protocols and best practices, and develop systems to routinely incorporate these practices.*

This ISG work group discussed the institutional and professional “cultures” that exist and how they impact the issue of patient safety. The institution, as well as the individual professions within the institution, must migrate to a culture of system improvement, away from the culture of “shame and blame” or the “culture of denial” that exists today. Institutions and individuals working in health care must be encouraged to acknowledge that medical errors and near misses occur so that all can learn from the event to prevent it from happening again to another patient.

To assist in the development of a culture of safety, the ISG work group made the following recommendations:

- each health care provider should develop a ‘safety plan’ that emphasizes the importance of reporting and rewards individuals who do report;
- all health care providers should implement ‘best practices’ in medication and medical administration;
- each facility and provider should increase reporting of near misses, risk and adverse events; and
- governing boards and management’s responsiveness to reported near misses/adverse events must be appropriate and set the culture within the organization.

Individuals should be encouraged to report proactively, before a “near miss” turns into an adverse event. Health care needs to migrate toward a culture where individuals can and do report near misses and adverse events without fear of reprisal. All providers need to develop a culture where it is routine to inform patients and their families when adverse events occur. Providers may wish to use the American Hospital Association’s guidelines for reporting adverse events to patients and their families. Hospitals, physicians, and other health care providers need to migrate toward a culture where reporting an adverse event or near miss is not equated with poor care or negligence. However, if negligence is suspected, reporting to this system does not relieve one of the responsibility of reporting that suspected negligence to the State.

The ‘culture of safety’ holds institutions and providers accountable to the patients and families they serve. It acknowledges that adverse events and near misses do occur. It makes understanding how the event occurred, and what can be done to prevent it in the future, a primary goal. It encourages reporting through a user-friendly reporting system. A ‘culture of safety’ places an emphasis on system improvement as a means of reducing adverse events. It encompasses all employees who share equally in the responsibility of improving patient safety. A culture of safety acknowledges that threats to patient safety are the result of a complex system

of care and may be caused by faulty equipment, system design, and the interplay of human factors, including fatigue, limitations on memory, and distraction. A culture of safety promotes:

- learning about the causes of error and using this knowledge to design systems of care that prevent error when possible;
- revealing errors and near misses that occur so they can be prevented in the future; and
- mitigating the harm done when an error impacts the patient.

**ACTION:**    **Develop** a safety plan for all health care facilities. The Culture Work Group has developed a template for a safety plan for use by all facilities, which will be provided.

**Develop and implement** a procedure to assure that “best practices” are routinely implemented on a timely basis.

**Sponsor educational programs** on patient safety initiatives; for example, on the appropriate identification and reporting of near misses, strategies to minimize/eliminate the occurrence of errors, etc.

**Identify** patient safety initiatives utilized in other states to determine what is feasible for implementation by Nebraska health care providers.

## The issue of ‘Barriers’

- *We must first understand the barriers that exist to identifying and sharing patient safety information.*
- *We must work to remove those barriers so that, to the extent possible, risk-free care is provided to all patients.*

One of the most important barriers to increasing patient safety is a lack of awareness of the extent to which errors occur daily in all health care settings and organizations. In today’s health systems, the vast majority of errors are not reported because personnel fear they will be punished. To be effective, health care providers must have a culture that fosters openness, collaboration, teamwork, and learning from mistakes.

The ISG work group has recommended that information about near misses and adverse events should be shared among all health care facilities and all health care providers. To accomplish this:

- participation in the reporting system should be voluntary;
- participation in the reporting system should be easy for the patient, the patient’s family and for the organization; the information should be de-identified as to patient, institution and health care providers;
- the information shared with all health care providers needs to include the steps implemented by the original institution to improve their process; and
- the confidentiality of the information needs to be maintained.

To break down the barriers, there must be a culture that encourages reporting and protects the person reporting, as well as the information reported. There must be a recognition that all health care providers share equally in the responsibility to report near misses, to learn from these near misses, and to institute changes to the care delivery process that minimizes or eliminates these near misses.

**ACTION:**    **Develop** a system of reporting near miss/adverse event information.

**Develop** a culture that encourages reporting and one that acknowledges that all health care providers share equally in the responsibility to report.

**Provide statewide education** to assist health care providers to develop a culture of safety in their facility.

**Assure adequate legislative protection** for reporting, for educational purposes, information regarding near misses and medical errors.

## **The issue of ‘Funding’**

- *Adequate funding must be obtained to support the information system needed to adequately collect and disseminate essential information regarding patient safety.*
- *Multiple stakeholders should contribute to funding the patient safety initiative in Nebraska.*

Any system implemented must have a source of funding. It is recommended that a future work group:

- explore grant opportunities to fund a state-wide reporting system;
- explore the use of Nebraska’s schools of medicine, pharmacy, and nursing to staff the review team;
- explore the use of associations such as the Nebraska Hospital Association, the Nebraska Medical Association and the Nebraska Pharmacists Association, to be responsible for disseminating information;
- explore the possibility of obtaining a discount on malpractice insurance premium cost if the provider is participating in the voluntary reporting system; and
- investigate the possibility of insurance companies helping fund the reporting system.

**ACTION:**    **Identify** funding sources prior to implementation.

## The issue of ‘Confidentiality’

- *Information reported under this system must remain confidential.*
- *Health care facilities and providers must be confident that they can report without fear of retribution.*

Before any reporting can begin, a legal review would need to be done to assess whether health care facilities and providers would incur any additional liability due to the reporting of near miss/adverse events as proposed in this report. Additionally, individual health care providers would need assurances that they can report near misses or adverse events without fear of retribution. If necessary, legislation may need to be developed and adopted prior to the initiation of any reporting.

**ACTION:** **Initiate legal review** of existing statutes to determine whether statutes are adequate to protect information, reported for the purposes of education, regarding medical errors and near misses.

**Identify** entities that would support, as well as those who would oppose, such legislation and begin to dialogue with them.

**Draft** legislation as appropriate, if existing statutes are inadequate.

**Obtain** legislative approval.

## The issue of ‘Reporting’

- *Reporting should be done on a voluntary basis;*
- *All health care facilities and providers should report selected information;*
- *Information to be reported should be well defined;*
- *Information reported should be used for educational, not punitive, purposes;*
- *Information reported for this purpose is not discoverable from this source;*
- *Information should be analyzed;*
- *Education should be provided to all health care providers, as a result of the analysis, so that care delivery processes can be improved at all facilities.*

It is the recommendation of the ISG on Patient Safety that reporting of selected information should be implemented. All health care providers -- hospitals, nursing facilities, physicians, nurses and other health care professionals -- should be charged with the responsibility of reporting adverse events and near misses **for the purpose of education and prevention of future occurrence of similar incidents.** A separate system exists for reporting, to the State of Nebraska Health and Human Services System, incidents where gross incompetence, practicing without a license, practicing while impaired by alcohol/drugs or physical, mental or emotional disability are suspected to occur. That reporting to the State of Nebraska Health and Human Services System is not part of the reporting system proposed by this ISG.

The purpose of the system proposed here is for education and prevention, not punishment. The following recommendations are made by the ISG on Patient Safety:

- A statewide system of voluntary reporting should be implemented. However, it is important, and essential, that **all** health care providers participate in this system.
- State statutes should be reviewed to determine whether they are adequate to protect the confidentiality of any information reported for this purpose. If it is determined that protection is inadequate, legislation must be drafted and approved prior to any reporting.
- Reporting/review mechanisms that exist today in health care facilities should be reviewed to identify the best practice and provide a model, based on those best practices, for use by all other Nebraska health care providers. The ISG believes that this will help facilities and providers identify incidents, conduct their own facility specific review, and implement the appropriate system changes. Investigate methods of on-line reporting.
- Identify specific patient safety information that should be reported to a central location. While all incidents could be reported, it is not anticipated that the resources necessary to adequately analyze this information would be initially available. Therefore, the ISG recommends that selected patient safety initiatives be identified and reported. Definitions and/or specific ICD-9-CM codes should be identified by the ‘central location.’ The ISG recommends that existing, generally accepted definitions, if available, be utilized; i.e., the NCCMERP.

- Selected information from individual facilities would be forwarded to a ‘central location.’ It would be the responsibility of the central location to assure that the information received was de-identified as to individual patient, facility and health care staff. Again, the purpose for sharing this information is for education, not punishment. The ‘central location’ could be the Nebraska Hospital Association, the Nebraska Medical Association and/or the Nebraska Pharmacists Association, or some other entity.
- The ‘central location’ forwards the de-identified information to a review team, which would develop a ‘recommendation for prevention’ that can be shared with all facilities. The review team assesses the patient safety area (root cause analysis), and develops the recommendation for prevention to be shared with all providers. The review team must consider the appropriateness and applicability of the recommendation to large and small facilities.
- The review team would be composed of physicians, hospital representatives, pharmacists, nursing facility representatives, medical school representatives, pharmacy school representatives, nursing school representatives, nurses and other health professionals as appropriate.
- The review team would develop and make available the recommendations for prevention for all facilities to use as applicable.

**Action:**        **Develop legislation** to protect the confidentiality of information reported, records submitted; obtain a legal review of proposed reporting format, draft legislation as needed to maintain the confidentiality of the information reported under this model, obtain sponsor for legislation; monitor through legislative process until adopted.

**Identify best practices** for reporting patient safety initiatives; propose a model that could be used by all facilities.

**Identify the patient safety initiatives** to report initially. Consider volume, degree of harm, etc.

**Investigate** methods for on-line reporting

**Develop and implement** (assumes appropriate statutory protection) reporting system.

**Establish review team** members and structure.