Patient Safety First

Patrick E. Voight RN BSN MSA CNOR

President Association of periOperative Registered Nurses (AORN)

The very first requirement in a Hospital is that it should do no harm

Florence Nightingale
Notes on Hospitals, 1859

Jumbo Jets Crash Every Day

Institute of Medicine Report – 1999 "Hospitals Can Be Dangerous Places"

- The report highlighted the now-famous statistics
  - 44,000 – 98,000 Americans die each year of medical errors
- These numbers led to:
  - Reporters to reach for their laptops
  - Politicians to reach for their microphones
  - Patients to reach for their valium

Institute of Medicine (IOM)

- **Founded in 1970 as the National Academy of Science – think tank for healthcare issues**
- **IOM report was based on 2 prior studies – Dr Lucian Leape – Harvard completed study 15 years prior**

IOM Mission – to provide "objective, timely, authoritative information and advice concerning health and science policy to government, the corporate sector, the professions and the public"

The Impact on Trust Can Be Non-Recoverable

- **New York Times:** Errors That Kill Medical Patients
- **JAMA:** Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of…
- **Time:** The Wrong Drug, The Wrong Dose
- **CNN:** Medical Errors Kill Tens of Thousands Annually
- **HealthLeaders:** First Do No Harm
- **USA Today:** Medical injuries wreak havoc beyond patients' pain and suffering ; Study: Extra costs, longer hospital stays cost billions

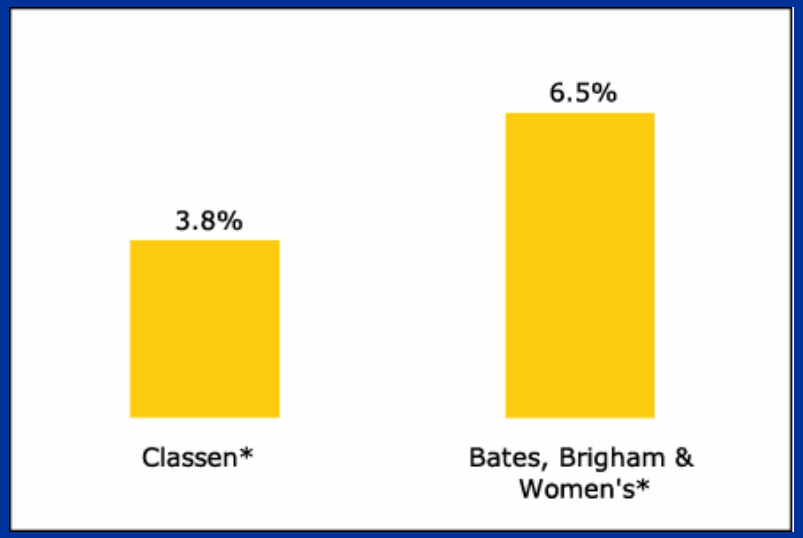
The Economic Impact Is Staggering

- The additional LOS attributable to an Adverse Drug Events (ADE) is between 1.7 days and 2.2 days[1]
- The cost per ADE was estimated to be approximately $2500, adjusted for inflation it is $4,000[2]
- For every 25,000 admissions, the ADE cost is $3.2 million
- Total national cost is estimated to be between $8.5 billion to $29 billion[3]
- Thirty percent of all direct healthcare outlays are the result of poor quality and inefficiency[4]

Is There Cause for Concern?

- In outpatients, 27.6% of ADEs are preventable with over half of these attributable to errors in prescribing or inadequate monitoring1
- Potential ADE rates for children are three times that of adults with 79% of potential ADEs at the time of drug ordering2
- Only 55% of patients in a recent study received recommended care regardless of acuity, i.e., preventive, acute and chronic3
- The lag between the discovery of more effective forms of treatment and their incorporation into routine patient care is in the range of 15 to 20 years4

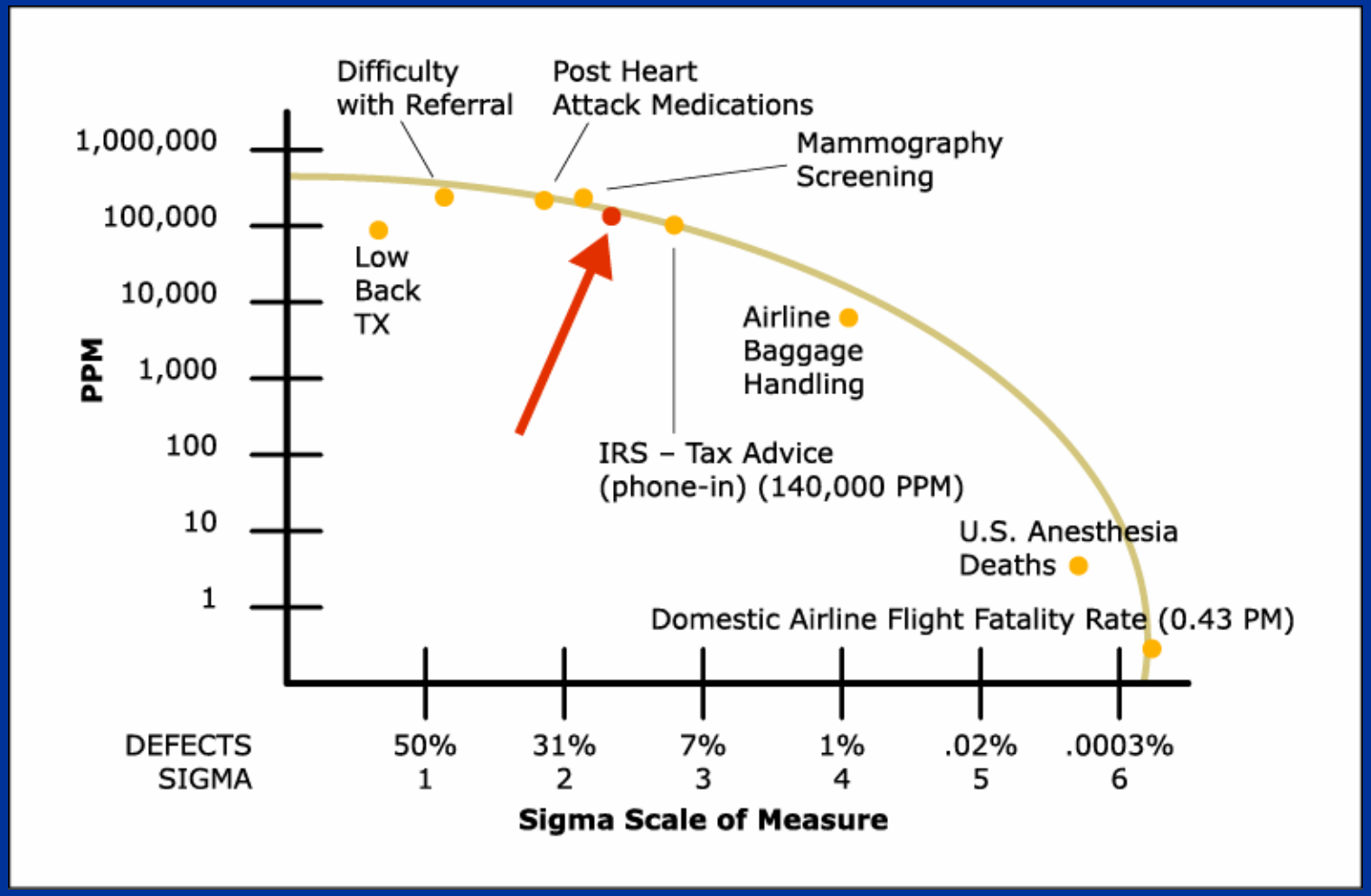
How Common Are Adverse Drug Events?



*Rates per 100 admissions

(Classen et al., JAMA 1991; 266: 2847-2851)
(Bates et al., JAMA 1995; 274: 29-34)

How Reliable Is Health Care?



Media reports of medical errors would lead one to believe that the problem is relatively straightforward and could be solved by:

- Reporting all errors to newspapers and to regulators
- Purging bad apple physicians and nurses
- Allowing sleep-deprived residents and interns to get a little shut-eye

However, most errors are made by good but fallible people working in dysfunctional systems, which means that making care safer depends on buttressing the system to prevent or catch the inevitable lapses of mortals

Leape says...

Incompetent people are, at most, 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes and it's the process that set them up to make these mistakes.

Several important points to remember regarding our healthcare delivery system

1. Most American hospitals are safe for the vast majority of patients, the vast majority of the time
2. The vast majority of our caregivers are well trained and conscientious
3. Western medicine's ability to save and extend life, and to improve the quality of life for the chronically ill, is nothing short of miraculous

Like peace officers, firefighters, and members of other lifesaving professions, most medical caregivers will be there when you need them, will know what they are doing, and will try to do the right thing – and usually succeed

“Surgeon Removes Wrong Part of Brain!”

- **The knee-jerk response is to fire the surgeon, but this leaves unfixed the various underlying factors that could place the next 100 patients at risk for a sequel**

“We must change the script”
Not the Characters

"Systems Thinking"

- Carefully developed and applied sets of:
  - Rules
  - Checklists
  - Standards
  - Technologies
  - Training programs that helps good caregivers give good care and prevents them from inadvertently harming their patients
- Creating a culture that prizes safety, focuses on it as a core professional value, and is open to discussing errors and learning from them
- System thinking is both – proactive & reactive

“Theory of Error” – James Reason

Most human endeavors could be compared to a chisel, with a sharp end that splits the wood and a blunt end that receives the hammer blows to drive it

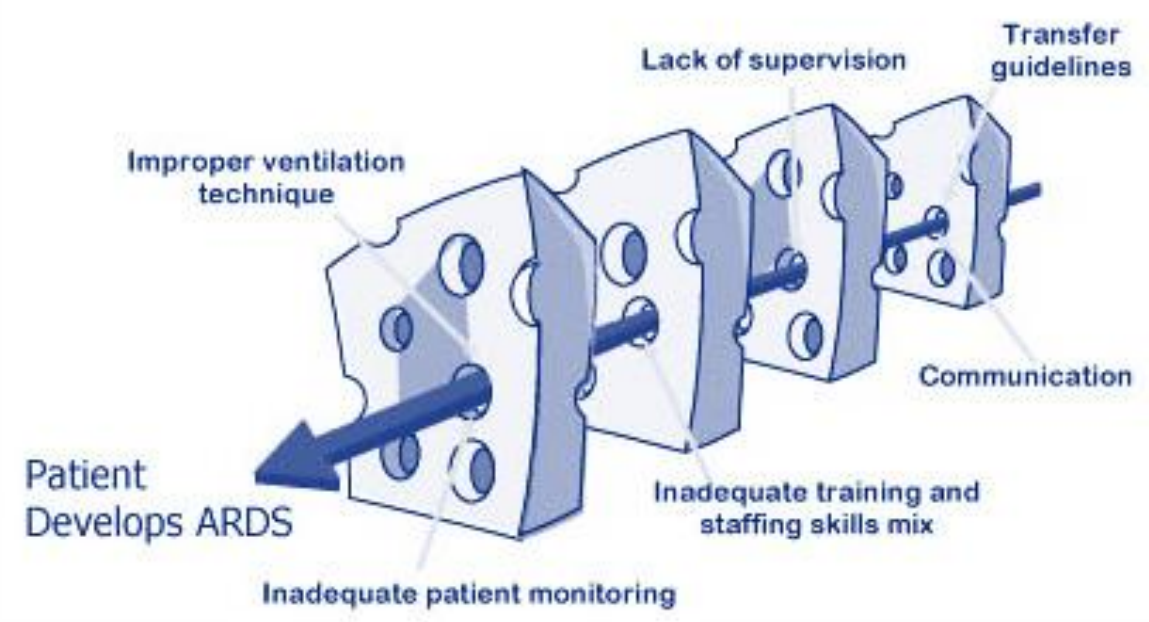
- **After major medical errors, we tend to blame those operating at the “sharp end” of the activity**
- **Frequently, their has been little attention to the “blunt end” of the activity**

“Human fallibility” is like gravity, weather, and terrain, just another foreseeable hazard

- **Sharp-end Workers must have adequate training, motivation, and self-discipline to do their jobs safely**
- **Blunt-end Managers must see that the sharp-end workers have all the tools they need, policies, procedures, training, orientation, etc – and make sure that they use them**

“Swiss Cheese” Model – James Reason

Multiple small errors in a complex system reach patients only when many holes in the protective barriers align to let them through



On most days the holes do not align, however……

Root Cause Analysis

- Root Cause Analysis (RCA) attempts to write a “second story” about the actions that led to error – to look past the obvious, sharp-end scapegoats
- RCA converts obvious “first story” questions like “who did it’ and “who is responsible” to subtler inquiries such as “how did this happen?” or “why did they do what they did?”

NASA: The Challenger Disaster – January 1986

NASA: The Columbia Disaster – February 2003

“Creeping Determinism” – Baruch Fischoff

The tendency to see events that were completely obvious in hindsight

- **We tend to become accustomed to small errors and routine malfunctions, and as a result, ignore what in retrospect are obvious red flags**
- **Accommodating frequent glitches is part of what allows workers to continue functioning------if we investigated every signal or alarm, we would never get any work done**

Overtime, the procedures we use and precautions we take as nurses, physician, etc.--- accumulate like barnacles on a ship

Position Statement on Just Culture (Patient Safety)

- AORN believes that all health care organizations must strive to create a culture of safety
- Commitment to safety must be articulated
- Patient safety initiatives will fail in the absence of a viable safety culture
- Safety the top priority, even at the expense of productivity
- Health care organizations should allocate resources, provide incentives/rewards as a promotion vehicle

AORN

Just Culture

- A just culture: actions are analyzed, individual accountability is established
- It is not a blame-free environment
- A learning culture includes the organization's willingness/ability to draw the correct conclusion from safety data and the responsibility to implement the needed strategies for reform
- Disciplinary policies balance the benefits of a learning culture with the need to retain personal accountability and discipline

AORN

Is Healthcare Safer today since the release of the Institute of Medicine Report?