Life, Liberty and the Pursuit of Quality and Safety in ORL Nursing

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Objectives
• Discuss the components of building a culture of quality and safety in your organization
• Discuss the National Patient Safety goals as they relate to the practice of ORL nursing
• Describe programs of disclosure and apology

Key Milestones in the Quality Journey
• 1991 The Institute for Healthcare Improvement (IHI)
• 1999 To Err is Human-Building a Safer Health System (IOM)
• 2009 The Joint Commission Center for Transforming Healthcare
• 2010 Appointment of Donald Berwick, Director of CMS

Donald Berwick Appointment
• Donald Berwick was sworn in Monday (July 12, 2010) as head of the U.S. agency that administers Medicare and Medicaid amid persistent political squabbling about his appointment
• Berwick, co-founder of the Institute for Healthcare Improvement, is the country's leading evangelist for the proposition that it is possible to deliver higher quality medical care at a lower cost.
  • He has not only preached that gospel; he's shown that it can be translated into reality.

The Challenge Ahead
• The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.

  "Donald M. Berwick, MD, MPP
  President and CEO
  Institute for Healthcare Improvement"

Quality and Safety

More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer, (42,297) or AIDS (16,516).
Safety at Sea for a Thousand Years

“Nothing is more dangerous than to be grudging in taking safety precautions….. lest they turn out to have been unnecessary.”

Admiral Nimitz

The Gulf Spill Disaster

• BP observed…difficulty landing the top plug into the casing shoe…First “red flag”
  • 8:20 pm on the day of the explosion
    – Pressure was increasing
    – During this 14 minute period, hydrocarbons were flowing and pushing more fluid from the wellbore than was being pumped in
    – BP rig supervisors should have gone to a well kill operation in which heavy mud is pumped back into the wellbore to restore the primary control mechanism

The Gulf Spill Disaster

• A decision should have been made to do a remedial cement job; having seen a 1,400 psi response…there was no choice
  • 9:08 Sea water pump was shut down. A pressure increase was seen…and again, at this point, kill operations should have been initiated
  • 9:15 Pressure continued to increase; again should have prompted a kill operation
  • 9:30 Seawater pump was again shut-in to presumably observe what the well was doing, again there is a notable increase in the standpipe pressure

The Well is Finally Capped

• July 16 Major leak stopped
• July 19 Question regarding some leakage remains
• July 27 CEO Tony Hayward resigns
• Plan is to cap well in August

The Gulf Spill Disaster

• “The Oil Disaster is about Human, not System, Failure”
  – Terry Barr, President, Samson Oil and Gas, Lakewood, CO. Wall Street Journal, 6/11/2010
  – BP has taken the position that this tragedy is all about a fail-safe blow-out (BOP) failing
  – In reality, BOP is just a ‘back up’ system
  – Industry practice and construction systems are aimed at ensuring that one never has to use that device.
  – The industry has for decades relied on a dense mud system to keep the hydrocarbons in the reservoir, maintain wellbore integrity test
  – The well failed its test and nothing was done
  – Data was collected and ignored
  – Nothing was done
  – “This spill is about human failure” Mr. Barr
Where was the Culture of Safety?

- Did the human beings involved oversimplify the situation?
- Ignore the results?
- No one spoke up to avoid the disaster? Why?
- What did BP learn?
- What is the culture of safety in your organization?

Cultures of Safety

- Southwest Airlines has not had any fatal events involving a passenger since it began service in 1971. www.airsafe.com/events/airlines/
- Safety in the nuclear industry—In more than 45 years of using nuclear energy, not one single fatality has resulted from radiation exposure. cna.ca/english/how_works/safety.html

To Err is Human

- 33.6 million admissions to US hospitals in 1997
- 44,000 Americans die each year as a result of medical errors
- Two large studies on hospital errors from Colorado/Utah and New York found adverse events occurred in 2.9 and 3.7% of hospitalizations

Some Progress Has Occurred, but We Have a Long Way to Go

Hospitals have taken steps to reduce medical errors and injuries

- Computerized prescriptions: 81% decrease in errors.
- Including pharmacist in medical team: 78% decrease in preventable drug reactions.
- Team training in delivery of babies: 50% decrease in harmful outcomes, such as brain damage, in premature deliveries.

Source: Journal of the American Medical Association

Building a Culture of Quality and Safety

- “The problem is not bad people; the problem is that the system needs to be made safer....”

Institute of Medicine (IOM) Report (2000) To Err is Human: Building a Safer Health System

The Challenge Is....

“...The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm.”

(2001) Crossing the Quality Chasm: A New Health System for the 21st Century, p. 79
Definition of a Safety Culture
• Enduring, shared beliefs & behaviors that reflect an organization's willingness to learn from errors*
• 3 beliefs present in a safe, informed culture
  – Our processes are designed to prevent failure
  – We are committed to detect & learn from errors
  – We have a just culture that disciplines based on risk**


Changing Paradigm: National Health Care Reform
• From treatment to prevention
• Payment based on quality outcomes
• Intense focus on Quality and Safety
• Communication across the continuum

5 Tenets of Highly Reliable Organizations
• A High Reliability Organization (HRO) is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.

5 Tenets of Highly Reliable Organizations
• Preoccupation with failure
• Reluctance to simplify interpretations
• Sensitivity to operations
• Commitment to resilience
• Deference to expertise

Building a Culture of Quality and Safety
• Commitment from the Board of Directors
• Board should spend 25% of their meeting time on issues of quality and safety
• The Board should meet with one patient or family member who had one serious unanticipated outcome in their organization
• IHI estimates that Boards are now spending 23% of their time on quality and safety

Assess Your Organization
• What is the communication style of your leadership team?
• What is the reaction when an error occurs?
• Are you encouraged to think of ways to do things that result in improved quality and safety?
• Are you rewarded for challenging the “status quo”?
• Are quality and safety part of your mission/vision?
National Patient Safety Goals

- Goal 1: Improve the accuracy of patient identification
- Goal 3: Improve the safety of using medications
- Goal 7: Reduce the risk of health care-associated infections

Applicable to inpatient ORL units and office-based practices

Goal 1
Improve the accuracy of patient identification
- Use at least two patient identifiers when providing care, treatment and services
  - Applies to hospitals and office-based surgery
  - Wrong patient errors occur in all stages of diagnosis and treatment
  - Intent: reliably identify patients and the service/treatment intended
  - Acceptable to use name, an assigned ID number, telephone number or other person-specific identifier

Goal 3
Improve the safety of using medications
- Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings
  - Rationale: Meds or other solutions in unlabeled containers are unidentifiable.
  - Errors, sometimes tragic, have resulted from meds and other solutions removed from original containers and placed into unlabeled containers

Think Outside the Box
- The story of Deborah Adler, designer

Goal 7
Reduce the risk of health care-associated infections
- Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines
  - According to CDC, millions of people acquire an infection while receiving care, treatment, or services in a health care organization.
  - HAIs are a patient safety issue affecting all types of health care organizations.

Why does healthcare steer off course when it comes to Hand Hygiene?
- Healthcare is a fast-paced environment with multiple hand hygiene opportunities.
- Healthcare personnel often lack understanding for when hands need decontamination.
- Healthcare organizations often select products which do not promote healthy skin.
Tackling the Hand Hygiene Issue

“Joint Commission Center for Transforming Healthcare
Takes Aim at Patient Safety Failures: Top U.S. Hospitals
Identify Causes, Develop Targeted Solutions to Save Lives”

“Demanding that health care workers try harder is not the answer. These health care organizations have the courage to step forward to tackle the problem of hand washing by digging deep to find out where the breakdowns take place so we can create targeted solutions that will work now and keep working in the future. A comprehensive approach is the only solution to preventing bad patient outcomes.”

Mark R. Chassin, M.D., M.P.P, M.P.H., President, The Joint Commission

Programs of Disclosure/Apology

• Three basic principles have shown to reduce anger, lead to fewer lawsuits with lower settlements, decrease litigation costs and shorten the time to settle cases
  – Compensate quickly and fairly when inappropriate medical care causes injury
  – Defend medically appropriate care vigorously
  – Reduce patient injuries by learning from mistakes

What Happens When an Error is Made?

• AAO-HNS Committee on Patient Safety and Quality program track for the AAO-HNS Annual meeting on Apology and Disclosure
• HHS has appropriated $25M to examine projects which aim to curb medical malpractice lawsuits
• Potential ideas: special courts and programs like “Sorry Works” www.sorryworks.net
• Sec. Sebelius will award grants to support states and hospitals who find innovative ways to address the rising cost of malpractice
• Medically Induced Trauma Support Services: support services to patients who have experienced unanticipated outcomes from medical care (www.mitss.org)

I’m Sorry Programs

• chicagotribune.com
  VOICE OF THE PEOPLE
  (Letters) Why it is good to ‘fess up’ to patients
  Jerome Lerner,Director,Rush Mediation Center, Rush University Medical Center
  August 31, 2007
• 1995 Rush University Medical Center -has a program to acknowledge errors and attempts to fairly compensate patients who may have been injured as a result of those medical errors.
• The Rush Mediation Program - received national recognition for its unique and effective method of resolving disputes over medical malpractice.
• Established out of recognition that some patients may be injured at the hands of otherwise bright, skillful, dedicated and well-meaning health care professionals

Programs of Disclosure/Apology

• Injured patient selects two mediators
  – One is a plaintiff’s attorney -the other is a defense attorney
• An important part of each mediation is when the representative from the Medical Center looks the injured patient squarely in the eyes, accepts full responsibility for the injury the patient has sustained and offers a sincere and heartfelt apology.
• The culture is to inform patients about an error even if no harm resulted

Miracle on the Hudson
Questions?

THANK YOU