Inova's Commitment to Patient Safety and Quality Improvement

GME

The Inova's Commitment to Safety and Quality

- Patients are safer – quality of care is better – when ***all*** care team members can voice observations and concerns.
- A safety culture reflects an atmosphere of mutual trust - ***all*** staff members can talk freely about safety problems and how to solve them.
- A just culture ensures that anyone involved in a safety event, or reporting it, can be confident of being treated fairly.

The Inova's Commitment to Safety and Quality

To improve safety and reduce risk to the patient, Inova has chosen to focus on the following quality and safety initiatives:

1. **Perfect care** – by compliance with
   - Core Measures
2. **Promoting a Safety Culture** – by
   - Teamwork
   - Open communication
3. **Harm avoidance** – by strategies to eliminate
   - Specific patient safety indicators (PSIs)
   - Hospital acquired conditions (HACs)
   - Patient safety events
4. **Promoting a Just Culture** – by
   - Transparency
   - Non-punitive response to safety events

Everyone has the responsibility to support these initiatives in order to ensure the safety of our patients.

Core Measures: Focusing on Perfect Care

Perfect Care: Core Measures

Core measures are a standardized set of therapies and performance measures which have been proven to streamline care and reduce complications.

Core measures:

- include precisely defined specifications
- can be uniformly embedded/adopted into current care systems
- provide standardized data collection protocols
- can meet established evaluation criteria

Key Point to Remember: **Compliance is mandatory**

Perfect Care: Core Measures

Adult Core Measure Sets at Inova include care specific to:

- Venous thromboembolism [VTE]
- Acute myocardial infarctions [AMI]
- Heart Failure
- Pneumonia
- Surgical care – [SCIP - the Surgical Care Improvement Project]

Perfect Care: Core Measures

To comply with Core Measures requirements:

- Use standardized order sets upon patient admission.
- Review the core measures requirements at discharge in the EPIC Navigator.

Other Important Tips:

- Document VTE prophylaxis
  - If withheld – document why it is withheld.
  - Document on the day of, or day after, admission to the hospital.
  - Complete the DVT prophylaxis checklist to comply.

Perfect Care: Core Measures

Other Important Tips [continued]:

- **Discharge Instructions**
  - Document that Patients, or their caregivers, were given written discharge instructions.
  - Document any educational material provided about warfarin that addresses: compliance issues, dietary advice, follow-up monitoring, and the potential for adverse drug reactions and interactions.
- **Medication Reconciliation**
  - Discharge AVS [After Visit Summary] medications must match those in the discharge summary.

Promoting a Safety Culture

Safety Culture

- **Leaders** actively create an environment of teamwork and mutual respect.
- **All team members are**:
  - approachable
  - comfortable sharing information
  - able to contribute their expertise and express concerns
- "**Preoccupation with failure**": All team members are responsible for identifying and acting upon risky situations to avoid patient harm.

Safety Culture: Role of the Organization

The organization ensures that:

- **The Attending** physician for each patient is:
  - identifiable, privileged, appropriately-credentialed.
  - ultimately responsible for that patient's care.

- **24/7:** Every major department has 24/7 Attending presence in house.

Safety Culture: Role of the Resident

"See one, do one and teach one" is not acceptable!

Residents should **not** attempt to perform any procedure for which they :

- have not been trained or
- are uncomfortable

If unsure, a Resident is **required** to **ask for help.**

Residents are only permitted to perform those procedures, without direct Supervision, for which they have received approval by the Program Director.

Safety Culture: Role of the Resident

Safety issues vs. Supervision Concerns

In a safety culture, open communication is critical.

- Regardless of the time of day or night, be sure to notify the supervising Attending physician of:
  - any substantial controversy regarding patient care.
  - any serious change in patient's course or condition.
  - any death, need for surgery or transfer to a higher level of care.
  - transfer to another service for treatment of an acute problem.

- **Resident concerns regarding appropriate supervision must be reported** to any of the following:
  - department leaders
  - the GME director/DIO or
  - Resident Advisory Committee

Incidents will be handled in a protected manner and without danger of reprisal.

Safety Culture: Role of the Resident

- **Effective Communication**
  - Residents should use standard handoffs tools:
    - EMR (EPIC sign-out)-written sign-out
  - Residents should use structured sign-out communication tools:
    - SBAR
    - Face-to-face handoffs
    - Readbacks (most effective for confirming information/tasks)
    - Contingency plans ("if this, then that" instructions)

Safety Culture: Role of the Resident

Verbal Handoff Tools: *SBAR*

- Structured verbal communication tools
  - SBAR
    - transfer of critical information
    - improved physician and nurse patient care information transfer *in the in-patient setting of the Kaiser Permanente health system*
    - Phone communication with bedside RN

Leonard et al The human factor: the critical importance of effective teamwork and communication in providing safe care. *Qual Saf Health Care.* 2004; 13(Suppl 1): i85-i90.

Safety Culture: Role of the Resident

Key Points to Remember

- Teamwork and open, respectful communication create a climate of safety.
- Be attentive to risky situations [preoccupied with failure]
- Attending physicians supervise all patient care activities, including procedures.
- There is 24/7 Attending level presence in the hospital to supervise Resident activities.
- Effective Communication during Transfer of care: face-to face handoffs, structured (EPIC) sign-outs, contingency plans and read-backs to confirm tasks/information
- Speak up! Residents are required to report any significant safety issues.
- Residents can escalate any concerns without fear of reprisal.

Harm Avoidance: Eliminating PSIs and HACs

Harm Avoidance: Eliminating PSIs and HACs

Inova is committed to eliminating PSIs, HACs and patient Safety Events through harm avoidance strategies.

- **Hospital acquired conditions (HACs)** and **Patient Safety Indicators (PSIs)** – are adverse events and hospital complications.
- Tracking PSIs and HACs provides an opportunity to improve patient care by identifying problem areas.

Key Points to Remember: **Documentation Tips**

- Full and accurate documentation is crucial to distinguish a hospital acquired condition vs one which was present on admission (POA).
- **POA:** Always document if a condition is Present on Admission
- **Post operative Complications:** Use the term "post-operative" with caution – it may inappropriately mislead the Coder into linking a complication with a surgical procedure.

Harm Avoidance: Eliminating PSIs and HACs

PSIs and HACs - examples	PSIs and HACs - examples
Postoperative wound dehiscence	Stage III or IV Pressure ulcer
Accidental puncture or laceration	Foreign body left during procedure
Postoperative respiratory failure	Catheter associated UTI
Fall with injury	Surgical site infections
Iatrogenic pneumothorax	Poor glycemic control
Obstetric and Birth trauma	Postoperative hip fracture
Postoperative PE or DVT	Postoperative Sepsis
Postoperative hemorrhage or hematoma	Central line associated blood stream infection

Eliminating Patient Safety Events by Promoting a Just Culture

Just Culture

Within in the general safety culture, Inova's strategy for eliminating safety events focuses on promoting a just culture in which everyone feels safe in reporting safety events and incidents.

Two key requirements are:

- **Transparency** – personal and organizational and
- **Fairness** – in event investigation and follow-up

Just Culture

Transparency

When transparent:

- Team members take personal responsibility and report errors because they do not fear reprisals.
- The organization investigates errors and provides internal feedback so others can learn from mistakes.

Just Culture

Event reporting

In order to be transparent, Inova is committed to tracking, trending and sharing lessons learned from safety events.

- An electronic safety event reporting system is available to ensure the appropriate management of patient safety events and incidents.
- **Speak up!** Residents are also expected to report any potential or actual safety event or incident using the electronic system.
- Incidents are investigated and handled in a fair and just manner however the option to complete a report anonymously is also available.

Safety Always!

- Safety Always is Inova's Safety Reporting System

- What Gets Reported in Safety Always?
  - Errors that result in overt harm
  - Hazardous conditions
  - Procedures or processes not followed properly
  - Near misses
  - Great Catches
  - Employee injuries

Safety Always!

- Who reports using Safety Always?
  - **EVERYONE!** – Physicians, Nurses, Technicians, Administrative Staff, Ancillary Personnel, and everyone else on the Inova team. We all have a responsibility to our patients and future patients.

- How to Enter a Report:
  - Double-click on the Safety Always icon 

found on the LANDesk to open the Event Reporting Form.
  - Complete the form, being sure to fill in all mandatory fields.
  - Click the "Submit" button at the bottom of the form.

Just Culture

Fairness

- It is only possible to be transparent if everyone feels they will be treated fairly.
- A **Just culture**:
  - recognizes that **competent professionals inevitably make mistakes –and provides "consolation".**
  - acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations") **– and provides coaching.**
  - has **zero tolerance for reckless behavior.**

Human Error: Inadvertently completing the wrong action; slip, lapse, mistake

At-Risk Behavior: Choosing to behave in a way that increases risk where risk is not recognized, or is mistakenly believed to be justified

Reckless Behavior: Choosing to consciously disregard a substantial and unjustifiable risk

Just Culture: The Resident's Role

Everyone has the right to be treated respectfully and fairly. Expect this from others and provide it yourself.

- Be approachable and collaborative - set a positive tone.
- Listen to the concerns of others - respond appropriately.
- Note that an unwillingness to listen or intimidating behavior are not only barriers to communication but barriers to patient safety.
- Ensure clear, consistent communication- use structured communication tools:
  - Briefings, debriefings after surgery or encounters using hand-off forms.
  - Checklists.
  - Handoff tools: SBAR, Face-to-Face sign-outs, Read-backs

Just Culture: The Resident's Role

- When dealing with human error, remember:
  - most errors are impacted by a significant process failure and not human error
  - lapses should be dealt with consolation
  - deviations in procedure require education and coaching
  - Reckless behavior should be disciplined
- Foster transparency - share your own errors openly and encourage others to do so as well.

Just Culture

Key Points to Remember:

- In a just culture – everyone feels safe to report events because they know they will be treated fairly.
- Residents are expected to report safety events and incidents using the electronic reporting system.
- Structured communication tools ensure clear communication.
- Most errors are dealt with by consolation and coaching but reckless behavior is never tolerated.