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The VA and Patient Safety: Where we Stand Ten Years After To Err is Human and Launch of the VA National Center for Patient Safety

By Joe Murphy, APR, NCPS public affairs officer

It has been just over 10 years since the Institute of Medicine published its landmark study on patient safety, *To Err is Human*. The VA National Center for Patient Safety was also established in 1999. Veterans have a right to ask, “What has the VA accomplished?”

Simply put: More than any other health care system in the world. In fact, we’ve aggressively developed and deployed systems that are in use throughout the VA and have been adopted as a benchmark by health care organizations throughout the world.

Some might say that this cannot be so and provide a detailed example, such as a serious problem with endoscope reprocessing that the VA confronted last year.

Neither the VA nor any other health care system can or will ever be able to “eliminate all errors.” A key principle upon which NCPS was founded is that a patient safety program focused exclusively on eliminating errors will fail. Period.

We’re human. We’ll never eliminate all errors. The real goal is to prevent harm to patients. We pursue this goal so that we can significantly improve the probability that the desired patient outcome is achieved. How? By taking a systems approach to problem solving.

Historically, those in medicine have relied on people being perfect and equipment never failing. It never worked; and, for too long, most were afraid to admit it. It is time to abandon this failed approach that unrealistically requires personal perfection to make care systems succeed.

It’s time to look past the overly simplified answer – that an adverse event is always someone’s fault. The real cause is most often a chain of events that has gone unnoticed, leading to a recurring safety problem. It is seldom related to the actions of just one individual.

We at the VA take a preventive approach to improving patient care by looking for ways to break that link in the chain of events that can cause a recurring problem. We focus on building care systems

that are “fault-tolerant,” reducing or eliminating the possibility that harm can come to a patient. Such systems are designed to succeed even if individual components fail.

Fault-tolerant patient care systems are designed to prevent patient harm from individual error. The fault-tolerance principle has been used for years by the aviation industry and other high-reliability industries – industries with safety records that far surpass those of health care.

Taking the Systems Approach

We don’t just talk about making changes at the VA, we have implemented a series of initiatives that offer specific measures to improve patient care and enhance system-wide patient safety efforts. Below are just three examples.

Confidential Reporting

One of our first challenges was to create a confidential VA database to allow us to track and analyze the root causes of adverse events and close calls.

We developed the Patient Safety Information System, nicknamed “SPOT,” to do just that: It provides a confidential, non-punitive reporting system that allows users to electronically document patient safety information from across the VA so that lessons learned can benefit the entire system.

Since SPOT was launched in 1999, more than 16,500 Root Cause Analysis (RCA) reports and nearly 700,000 safety reports have been placed in the system. Using specialized software, we can search SPOT for trends and for a listing of specific events.

Following the implementation of SPOT and other NCPS programs, we saw a 30-fold increase in event reporting and a 1,000-fold increase in the conduct of RCAs on events that were close calls, reflecting the level of commitment to the program by Veterans Health Administration leaders and staff.

Close calls are given the same level of scrutiny as adverse events that result in actual harm: that’s

Your VA Patient Safety Program at Work

Highlights of Advances Made 1999 to Present

By Joe Murphy, APR, NCPS public affairs officer

The VA patient safety program was established in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration. The primary goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care. A series of initiatives have been successfully developed to carry this out – specific measures to improve patient care and enhance VA-wide patient safety efforts. Below are a number of examples.

Issue

No confidential VA database available to track adverse events and close calls.

- *Resolution:* Develop the confidential, non-punitive Patient Safety Information System, nicknamed “SPOT,” to document information electronically.
- *Status:* More than 16,500 Root Cause Analysis (RCA) reports and nearly 700,000 safety reports have been recorded in the system.

Issue

No VA-wide program to investigate patient safety incidents, to include close calls.

- *Resolution:* Develop and support the conduct of RCAs at VA medical facilities.
- *Status:* 16,500-plus RCAs conducted to investigate adverse events and close calls – which occur 3-to-300 times more than actual adverse events.

Issue

No VA-wide program to proactively evaluate a health care process.

- *Resolution:* Develop Healthcare Failure Mode Effect Analysis (HFMEA), a five-step process used by interdisciplinary teams to evaluate a health care process.
- *Status:* More than 1,000 have been conducted since 1999 on issues ranging from developing backup medication delivery systems to improving how laboratory specimens are drawn.

Issue

No VA-wide patient safety training program.

- *Resolution:* Develop and implement an inclusive patient safety training program for VA employees, to include conduct of RCAs, HFMEAs, and the use of human factors engineering principles.
- *Status:* 32 sessions have been conducted to include more than 2,400 VA caregivers and professionals from 12 countries and 282 U.S. institutions or agencies.

Issue

Falls are the number one cause of reported adverse events at VA facilities, and a serious issue for hospitals nationwide.

- *Resolution:* Develop a number of initiatives in an effort to reduce falls at VA facilities.
- *Example:* The Falls Toolkit includes fall risk assessment tools, measurement and intervention strategies, and videos for analysis of balance and gait. More than 60 facilities participated in a project to spur toolkit usage, resulting in a 44 percent decrease in acute care unit falls and 64 percent in behavioral health units.

Issue

Many facilities did not conduct enough RCAs in a timely fashion.

- *Resolution:* Create the Cornerstone Recognition Program, begun in 2008, which rewards facility efforts to develop stronger and more timely RCAs. Facilities can earn bronze, silver or gold awards, based on the number of RCAs completed and the quality of the RCAs.
- *Status:* 71 medical facilities achieved awards in 2008; 122 facilities in 2009, indicating that nearly 80 percent of all VA facilities have achieved awards.

Issue

No objective manner to judge whether or not a culture of safety was being developed at VA facilities.

- *Resolution:* Create and conduct detailed patient safety surveys.
- *Status:* In 2000, more than 6,100 VA employees participated in the first survey; more than 45,250 in the second, in 2005; and more than 54,000 participated third survey, held last year. Questions covered 14 patient safety dimensions.
- *Example:* Senior management’s awareness and actions to promote patient safety significantly improved over the three survey periods: Improvement was seen, uniformly, in non-supervisor, supervisor and senior management survey responders.

Issue

Under utilization of VA information technology (IT) in support of patient safety.

- *Resolution:* Secure funding to support development of a number of IT projects on a wide range of patient safety issues.
- *Status:* Approximately \$34 million secured in the fiscal year 2010 VA IT budget for priority projects, such as bar code expansion and anticoagulation management.

Issue

Ineffective communication among clinicians is a leading source of adverse events in health care.

- *Resolution:* Create and implement programs to improve communication among clinicians.
- *Example:* Medical Team Training (MTT) was developed to improve

patient outcomes and staff morale through enhanced teamwork and communication. Phase I focused on operating room (OR) and intensive care unit staffs. It included 160 MTT learning sessions at 144 VA facilities that involved more than 12,000 VA employees. In a preliminary report from 110 VA facilities completing Phase I, 82 percent reported improved teamwork and 78 percent documented improved efficiency in the OR. Phase II is currently underway and focuses on non-OR care areas, such as: cardiac catheterization units, endoscopy suites, and med/surg floors.

- *Example:* The Nursing Crew Resource Management Program is in development for front-line nurses and being piloted at several VA medical centers. Like MTT, it focuses on effective use of all available resources – information, equipment, and people – in operational decision making.

Issue

No VA-wide support for local efforts to improve facility design.

- *Resolution:* The Patient Safety Design Challenge allows facilities to create a positive impact on design standards at VA facilities nationwide.
- *Status:* Five teams have been recognized since 2006.

Issue

No VA-wide to support for facility-specific patient safety initiatives.

- *Resolution:* The Patient Safety Initiative stimulates creative approaches to complex patient safety issues at the local level.
- *Resolution:* Nearly 80 projects have been funded since fiscal year 2006.

Issue

No VA-wide program to involve residents in patient safety efforts.

- *Resolution:* Patient Safety Curriculum Workshops for Residents fosters an

awareness of patient safety during early clinical training.

- *Status:* 750 have attended from 50 university affiliates and nearly 100 VA hospitals, to include professionals from 42 states and six foreign nations.

Issue

No VA-wide effort to involve a cross-section of health care professionals in specific patient safety initiatives.

- *Resolution:* Develop the Patient Safety Fellowship Program, which offers education in patient safety practice and leadership for post-residency trained physicians and other post-doctoral or post-master-degree professionals.
- *Status:* 16 have completed the program; 11 are current fellows.

Issue

No VA-wide program to involve patients (or families) in their care.

- *Resolution:* The Daily Plan[®] offers patients a consistent manner of interacting with caregivers to better understand their care. A single document is offered to them that outlines what can be expected on a specific day of hospitalization.
- *Status:* The plan received a positive response from patients and staff in pilot tests at five facilities.
- *Example:* In the first pilot test, nurses assigned to patients receiving the plan during their shift completed a single end-of-shift accumulated evaluation: 35 percent reported one or more errors of omission that were identified and corrected; 21 percent indicated prevention of other potential adverse events.

Issue

On-time completion of Class 1 recalls inadequate. (Exposure to these products can cause serious adverse health consequences or death.)

- *Resolution:* Make ranked compliance data available to all VA medical facilities.
- *Status:* 98.2 percent compliance in March 2010 up from 64.9 percent in December 2008, following establishment of VHA Product Recall Office at NCPS. All actions must be taken within 24 hours to remove these products from use.

Issue

Create a method for teams at VA facilities to address specific patient safety issues.

- *Resolution:* Fund specific, long-term patient safety initiatives for teams at VA facilities around the nation through the Patient Safety Centers of Inquiry Program, begun 1999. The centers develop, disseminate, and implement clinically relevant patient safety innovations.
- *Status:* 12 centers have been funded since 1999, developing initiatives on wide range of issues, such as: falls injury reduction, safe patient handling, and medication reconciliation.

Issue

Lack of a national patient safety training program outside the VA.

- *Resolution:* Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ) selected NCPS to formulate, manage and implement a multifaceted training program for state health officials and their hospital partners. This landmark interagency agreement between HHS and VA was funded by AHRQ.
- *Status:* Initial training of representatives from all 50 states was completed in 2006; additional training sessions were offered in 2007 and completed in 2008; more than 300 health care professionals from 210 organizations participated in the program, including those from Washington, D.C., and Puerto Rico.

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because they have been shown to be 3-to-300 times more common than actual adverse events.

A willingness and an avenue to report problems is essential to safe care because *you can't fix what you don't know about.*

Patient Safety Training

We also recognized that the VA had no consistent patient safety training program, so we developed one. Our inclusive, one-to-three day training sessions present VA employees with specific ways to enhance patient safety efforts, such as:

- Developing and leading an RCA team
- Hands-on training concerning the use of the SPOT database
- Human factors engineering

Since 1999, 32 sessions have been attended by 2,400-plus VA caregivers, as well as representatives from 12 foreign countries and 282 U.S. health care institutions or agencies.

For a patient safety program to function effectively, developing a consistent method for training front-line patient safety professionals is critical.

Medical Team Training

Ineffective communication among clinicians is a leading source of adverse events in health care, a problem we knew we had to tackle.

One of our programs, Medical Team Training (MTT) was developed to improve patient outcomes through more effective communication and teamwork among providers in critical care areas, such as

the operating room (OR) and intensive care unit. MTT is based on the aviation industry's Crew Resource Management training, developed 25 years ago to address communication failure among air crew members.

Phase I began in March 2005 and included more than 12,000 VA employees who attended 160 MTT learning sessions held at 144 VA facilities. Phase II is currently underway, focusing on other care areas, such as mental health units and primary care clinics.

A preliminary report from the first 110 VA medical centers completing Phase I provided insight into the program's impact:

- 82 percent reported improved teamwork in the OR
- 78 percent documented improved efficiency in the OR

A Work in Progress

We will continue to improve and develop patient safety initiatives that make sense because they produce positive, systematic changes to reduce or eliminate potential harm to patients – and we have created a way to gauge the VA's progress.

Patient Safety Culture Surveys

Prior to carrying out the surveys, we had no objective measures to judge whether or not a culture of safety was being developed at the VA. In 2000, more than 6,100 VA employees participated in the first survey; more than 45,250 in the second, in 2005; and more than 54,000 participated third survey, held last year.

The Agency for Healthcare Research and Quality (AHRQ) cultural survey was based on the NCPS survey. Questions in the NCPS survey cover 14 patient safety dimensions and include five dimensions that overlap those in the AHRQ survey.

Overall national results from the latest NCPS survey were notable.

For instance, measurements of senior management's awareness and actions to promote patient safety have significantly improved over the three survey periods:

- This improvement was seen uniformly in non-supervisor, supervisor and senior management survey responders.

The survey indicated a favorable comparison between the VA and AHRQ benchmarks, as did the previous one. In particular, the VA has scored significantly higher in two measures:

- 80 percent to 70 percent in organizational learning
- 70 percent to 62 percent in feedback and communication

No significant differences were found in the three other dimensions: teamwork within hospital units, teamwork across hospital units, and frequency of event reporting.

The Bottom Line

Members of the VA patient safety program, whether at NCPS or VA facilities across the nation, have an unwavering commitment to assist and encourage all VA health care providers in their aggressive pursuit of patient safety initiatives that prevent inadvertent harm to patients as a result of their care.

Learn More
www.patientsafety.gov