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## The Safe Day Call

### *How a 15-minute call can significantly improve Veterans' Care*

*By Joe Murphy, APR, NCPS public affairs officer*

Cindy Paterson attended a workshop at an Institute for Healthcare Improvement conference where she learned of a daily call to discuss patient safety issues that was being held at a non-VA facility. She thought the idea of a daily call would be a great way to keep informed, keep the lines of communication open, and break down stove-piping. And it has worked.

She also believed that instituting the call would significantly improve communications and help resolve emergent issues. Paterson, an R.N. who holds a Ph.D in healthcare administration, is the patient safety manager at the VA Ann Arbor Healthcare System.

"I always felt like there was much more going on in the facility that wasn't being reported through our incident reporting system," she said, "which made weekly rounds with our chief of staff very frustrating. We would be out on the floor and staff members would say, 'Are you aware of this issue? Are you aware of this safety problem? Are you aware that this has occurred?' In too many cases, the answer was no. I just wasn't getting the information."

The facility implemented the Safe Day Call in 2010 and based the new program on a uniform approach to communication. Led by the patient safety manager, the call is held at 9:30 a.m., Monday-Friday. The agenda is always the same and staff members speak in the same order.

"Our call only lasts 15 minutes, every day," she emphasized. "It's really important to keep it short. This isn't a big discussion. This is about what's happening. What action do we need to take?"

Paterson starts the call by discussing such things as issues from the previous day, incident reports, the status of root cause analyses, product recalls, and patient safety alerts. Following this, representatives from 25 departments and the system's three community-based outpatient clinics report.

The initial part of the discussion is focused on the past 24 hours, concerning issues such as injuries, falls and medication events. "Then I ask the callers to look ahead: Are they expecting any new procedures? New equipment? Some new high-risk medication that might be coming out?" she said. "And, are there any changes that it's important for everybody on the call to know about?"

The results have been significant:

- 776 patient safety issues closed-out in fiscal year 2011, up from 154 in fiscal year 2010
- 607 patient safety issues resolved in fiscal year 2011, up from 168 in fiscal year 2010

"We consider an issue 'closed-out' when it can be addressed during the call," said Paterson. "For instance, a recent question came up about how to deal with bed bugs if they came into the facility. The infection disease coordinator was on the call, answered our questions, gave a mini 'in-service,' and followed-up by sending background information out to the staff."

A "resolved" issue indicates one that takes more time and staff work to address. In some cases, lots more time. "We had a problem with a code alarm that took a couple of months to solve. So everything is not always so clear cut, regardless of who is on the call," she noted.

Paterson uses a database to track each new issue and the actions taken to address it. "But again, it can be relatively easy to close things out quickly, because you can have pharmacy on the phone and nursing might

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# Redesigning Medication Alerts to Support Prescriber Decision-Making

*By Amanda Kobylinski, Pharm.D., former NCPS fellow; Alan J. Zillich, Pharm.D., health services research scientist and Alissa Russ, Ph.D., human factors research scientist, VA Health Services Research and Development Center of Excellence on Implementing Evidence-Based Practice*

A study that employs the use of human factors principles to improve medication order checks is being completed by investigators at the VA Health Services Research and Development Center of Excellence on Implementing Evidence-Based Practice, Roudebush VA Medical Center, Indianapolis, Ind.

VA order checks alert physicians, nurse practitioners, clinical pharmacists and others of potential drug-drug interactions, drug-allergy interactions, etc., as medications are being ordered in the VA's Computerized Patient Record System (CPRS).

Although the order checks are intended to facilitate appropriate therapy selection, several studies have suggested the alerts do not effectively support prescriber workflow and decision-making.[1-3]

The purpose of the study was to develop experimental redesigns for the order checks and carry out usability tests to determine if the redesigns improved prescriber workflow and clinical decision making.

## Redesigning order checks

This study focused on order checks for drug-drug interactions, drug-allergy and drug-disease alerts. Aspects of the order checks that were redesigned include: the presentation of allergy data; navigation to drug-drug interaction details; timing of drug-disease alerts; and the mechanism to enter a reason for overriding order checks.

The study team redesigned the order checks based upon previous research findings from observations of prescribers during routine clinical care[2] and other literature, input from a VA advisory panel, and by applying human factors principles.

The team used several human factors principles when redesigning "CROCS," the acronym for Clinical Reminder Order Checks. CROCs can be created at local VA medical Centers to supplement the order-check system that is used nationwide across the VA.

Patient safety managers and other personnel involved in developing CROCs may find the table we developed, which accompanies this article, as a helpful guide.

## Study impact

Study findings are ongoing and will be shared with VA informatics and safety leaders and the CPRS Clinical Workgroup. Future work will examine more complex design changes that are needed to support decision-making processes, such as changes to the clinical content of the alerts.

## Acknowledgements

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**Table - Design tips for Clinical Reminder Order Checks**

1. Before creating a new order check, ask:
   - Is an order check already available in the VA system, but is not set to 'ON' by the facility or end-user?
   - What evidence from the facility supports the need for an order check? How strong is this evidence?
   - Is there another way to address this issue *without* adding an order check (e.g., order set, etc.)?
   - Under what circumstances will the order check be a "false alarm" and not apply to the patient or prescriber? (It is very rare that an order check will always be applicable)
2. Reduce alert fatigue
   - Minimize the total number of order checks
   - Limit the amount of text on the order check and use short statements, not full sentences
3. Wording
   - Use terminology that is commonly understood by ALL of the intended end-user groups
   - Be explicit (e.g., "teratogenic" is better than "dangerous drug")
4. Format and content
   - Use ALL CAPS sparingly, as this increases the cognitive effort needed to read text
   - Avoid using technical informatic terms that are not commonly used by end-users
   - On the order check, present the data (e.g., lab values, dosing guidelines, etc.) that prescribers need to make a decision

## Developing a Culture of Safety

*By Joe Murphy, APR, NCPS public affairs officer*

NCPS was established in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration.

NCPS' goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care.

Patient safety managers at 153 VA hospitals and patient safety officers at 21 VA regional headquarters participate in the program.

A fundamental aspect of our approach to patient safety is the use of a multi-disciplinary team approach, known as the root cause analysis (RCA) process, to study adverse medical events and close calls (sometimes called "near misses").

The goal of each RCA is to find out what happened, why it happened, and what must be done to prevent it from happening again.

Training programs, cognitive aids, and companion software have been developed by NCPS staff to support facility RCA teams.

Neither the VA nor any other health care system, however, can or will ever be able to "eliminate all errors." Patient safety programs focused exclusively on eliminating errors will fail.

The real goal of a patient safety program should be to prevent harm to patients, by significantly improving the probability that a desired patient outcome can be achieved.

This can only be accomplished by taking a systems approach to problem solving, focusing on prevention, not punishment.

Historically, those in medicine relied on people being perfect and equipment never failing. It never worked; and, for too long, most were afraid to admit it.

NCPS was founded on the belief that this failed approach must be abandoned, as it unrealistically requires personal perfection to make a care system succeed.

The time had come 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 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.

The focus is on building care systems that are "fault-tolerant." Such systems reduce or eliminate the possibility that harm can come to a patient, because these systems are designed to succeed even if individual components fail.

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.

A systems approach to problem solving requires a willingness to report problems or potential problems so that solutions can be developed and implemented.

We created the Patient Safety Information System, commonly known as "SPOT," to support this requirement.

It's an internal, confidential, nonpunitive reporting system that allows users to electronically document and analyze patient safety information from across the VA so that lessons learned can benefit all caregivers.

Thousands of RCA reports and safety reports have been recorded in the system since NCPS was established.

Close calls are given the same level of scrutiny as adverse events that result in harm to a patient, as they may occur as much as 300 times more often than actual adverse events.[1]

Willingness to report problems, combined with a confidential means to do so, is essential to safe care because *one can't fix what one doesn't know about.*

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## The Safe Day Call

*How a 15-minute call can significantly improve Veterans' Care*

*Continued from page 1*

say, 'I have an issue with getting this medication delivered.' They're on the call, they hear it, and they take immediate action," stated Paterson.

In some cases, specific actions are assigned and follow-up is required by 3 p.m. on the day of the call. "For instance, if there has been a patient with a fall that's had an injury, we need to learn more information on what happened that same day," she noted.

Though the calls have become a routine way of doing business, at first, some resisted the change.

"Some would call and say to me, 'I know everything that goes on,' and I said, 'Give it a try, you don't know half of what's going on!" Paterson indicated.

"Others said, 'Oh not another thing. Not another call.' But within a short time, staff realized how many problems we could solve because of the call," she added.

Paterson said staff members now feel more involved with patient safety and more willing to discuss problems. "They don't feel hindered because they have to write something up," she said, "or it's going to look like they are tattling on somebody. They feel more comfortable. They can go to their supervisors and tell them what's happening. They know it's going to be on the call. That we are here to solve problems, not point fingers."

Initially, Paterson said it took her about hour to an hour-and-a-half a day to follow-up on various issues. But she also asked staff to get involved, follow-up on issues in their areas, and report back. "I probably spend about 45 minutes a day now doing follow-up. It's much better," she noted. "Someone on the call will say, 'I have this problem,' and another will say, 'Call me at the end of this call and we'll take care of it.' So okay guys – go for it! It makes it much easier for me."

The success of the Safe Day Call has led other staff to consider similar initiatives. "We are beginning to discuss an OR scheduling call," she said. "Instead of having to go from person to person to develop a schedule, staff have come to realize the value of having all those involved on the phone at the same time. And this could include looking at things two or three days in advance."

Her facility's good efforts have been noticed. Kelly Sermak, R.N., Veterans Integrated Service Network (VISN) 11 patient safety officer, learned of the Safe Day Call during an annual facility inspection. "I showed her what we were doing," Paterson said. "She began to speak to the staff and they couldn't stop raving about it."

In particular, Sermak was impressed by the way staff talked openly about issues and concerns. "I thought this is something the entire VISN should be doing," she said. "And there was no requirement for additional financial or administrative resources, a big plus."

She believed the call would significantly enhance patient safety reporting efforts. "The staff said it was better than writing something up because they saw an immediate response," said Sermak. "And the literature indicates that people tend to report if they believe someone is going to do something about their concerns."

She noted that staff members also felt safe reporting an issue to their supervisors, knowing it would be mentioned on the call. "They gave me example after example," Sermak stated.

"You are putting yourself out there when you report an issue," she continued. "And we are trying to get away from anonymous reporting so that we can provide rapid feedback to staff. The fact that actions can be taken quickly, based on the call, really makes a difference."

Mutual problems can also be recognized. "When one unit raises an issue, others may report a similar problem," Sermak noted. "So you get an aggregate and can say, 'Yes, we really need to look into this. It's not an isolated problem.' "

Following approval of the program for VISN-wide implementation, she worked with Paterson to get facility leaders directly involved. "I talked to Cindy and asked if the directors could dial in. She readily agreed. So they could hear for themselves how much was getting done on a daily 15-minute call!" she said.

The program began VISN-wide on October 1, 2011. "We asked that facilities start with a small group and add others to the call as time progressed," Sermak said. "I told them this would help make our network a safer place. Better for Veterans. Don't worry about push-back, it won't last."

"I am getting ready to start my annual patient safety reviews and data from the calls will be one of the areas I study," she continued, "But I see this as more than just another way to report, it really can change the culture."

Paterson also sees the call in larger terms: "The number one thing I would say about the Safe Day Call is that it promotes a culture of safety. It's an interdisciplinary, departmental communication. It's focused, simple, systematic. It improves teamwork and it helps to reduce silos. Front-line leaders and staff get recognition for their good work. It really promotes safety awareness."