To Err is Human:
Interprofessional Solutions to Improve Healthcare Quality

Mary A. Dolansky, PhD, RN, FAAN
Independence Foundation Professor of Education
Frances Payne Bolton School of Nursing
Director of the QSEN Institute

Nurse Adviser National VA Quality Scholars Program
VAQS Senior Nurse Fellow
Louis Stokes Cleveland VA

FRANCES PAYNE BOLTON SCHOOL OF NURSING
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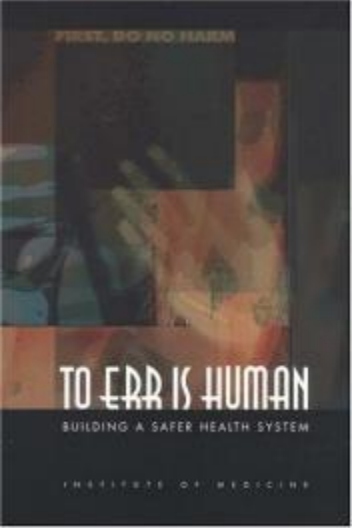
Overview

- Current State of Safety
- Primary Care
- Interprofessional Solutions



To Err is Human

Beginning in 2000, the Institute of Medicine released a series of reports that brought attention to the issues of quality. The first, *To Err is Human* brought startling statistics to light about the number of needless deaths and injuries caused by medical errors.

Annual deaths

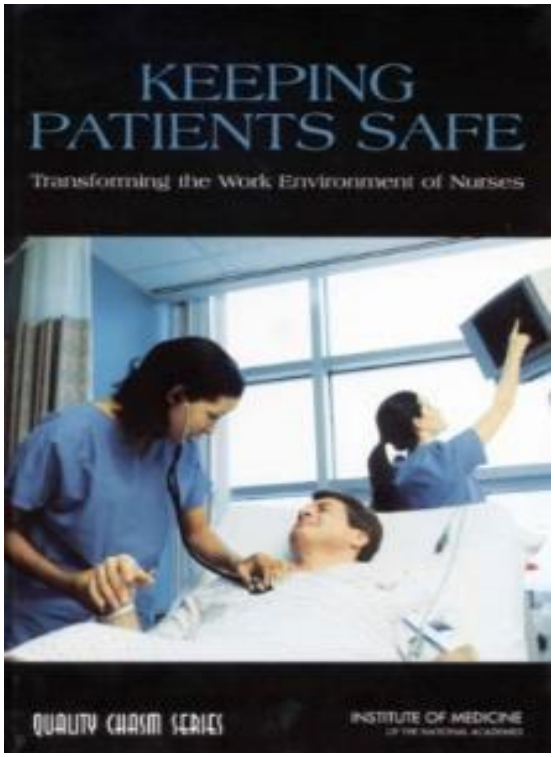
- AIDS---------- 16,516
- Breast cancer---------- 42,297
- Motor vehicle accidents---- 43,458
- **Medical Errors---------- 98,000**

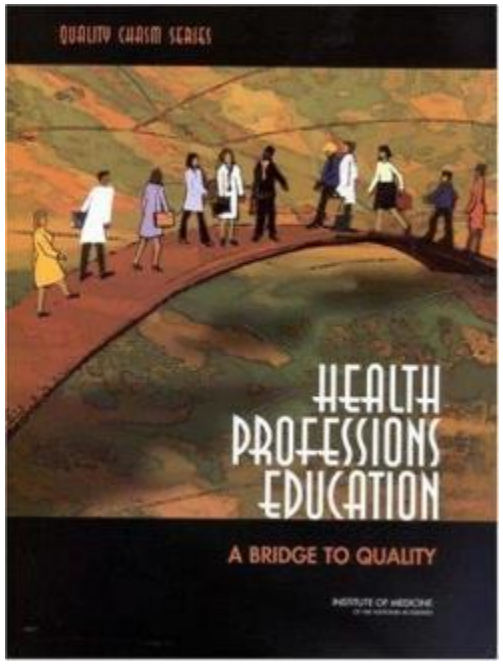
Crossing the Quality Chasm

The second report, *Crossing the Quality Chasm*, provided a definition and aimed to improve quality of care. In this report, the Institute of Medicine defined quality as:

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Subsequent IOM Reports

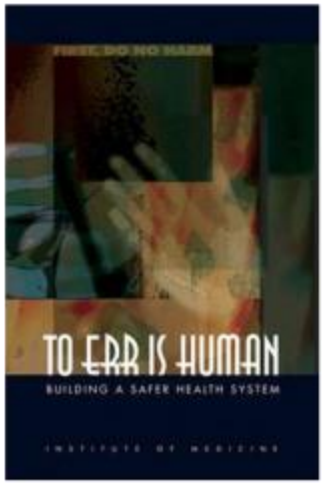




http://www.iom.edu/Reports.aspx

Reports are free electronically

History of Quality & Safety



THE TRIPLE AIM

HA HealthAffairs

FROM TRIPLE TO QUADRUPLE AIM: CARE OF THE PATIENT REQUIRES CARE OF THE PROVIDER

ANNALS OF FAMILY MEDICINE

1999 2001 2008 2014 2015

"Deaths from Medical Errors are Equivalent to 10 Jumbo Jets Crashing Each Week"

J. T. James, "A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care," Journal of Patient Safety, 9, no. 3 (September 2013): 122–28

"Patients frequently experience harms that could have been prevented or mitigated"

Free from Harm Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human, 2015

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World Health Organization
Helen Haskell – President, Mothers Against Medical Error and Consumers Advancing Patient Safety; Steering Group, World Health Organization Global Patient Safety Challenge on Medication Safety

Medical Error is Real and Common

- Centers for Disease Control and Prevention (CDC)
  - each year nearly 2 million patients in the United States get an infection while being treated for another illness or injury,
  - nearly 88,000 die as a direct or indirect result of this infection — adding nearly $5 billion to health care costs every year. [1]

- Centers for Medicare and Medicaid Services (CMS)
  - one million patient safety incidents occurred to hospitalized Medicare patients in the US over the years 2002 to 2004,
  - causing more than 250,000 deaths and costing $9.3 billion.[2]

[6]Hospital infections cause US billions of dollars annually. Centers for Disease Control and Prevention website. Available at http://www.cdc.gov/media/pressrel/r2k0306b.htm.

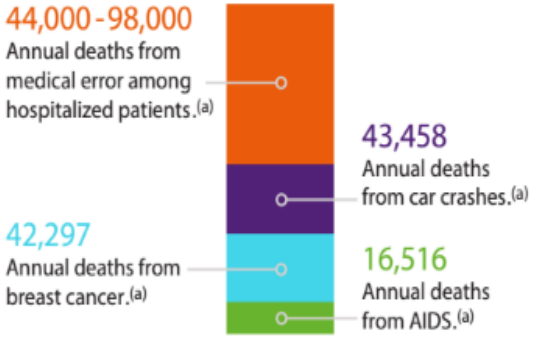
[2]Hospital errors cost Medicare $9.3 billion over three years. Senior Journal.com website. April 3, 2006. Available at http://seniorjournal.com/NEWS/Health/6-04-03-MedicalErrors.htm

FREE FROM HARM:

ACCELERATING PATIENT SAFETY IMPROVEMENT FIFTEEN YEARS AFTER *TO ERR IS HUMAN*

Report of an expert panel convened by the National Patient Safety Foundation argues for looking at morbidity as well as mortality caused by medical errors and going beyond hospitals to improve safety across the continuum of care.

TO ERR IS HUMAN FRAMED PATIENT SAFETY AS A SERIOUS PUBLIC HEALTH ISSUE (1999 ESTIMATES)



BY SOME MEASURES, HEALTH CARE HAS GOTTEN SAFER SINCE TO ERR IS HUMAN

1.3 Million

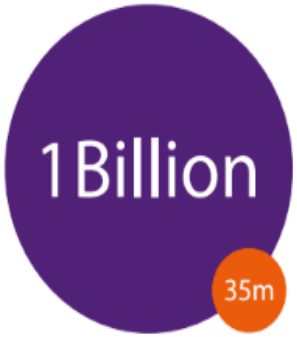
Estimated reduction in hospital-acquired conditions (2011-2013) as a result of the federal Partnership for Patients initiative.(b)

TO UNDERSTAND THE FULL IMPACT OF PATIENT SAFETY PROBLEMS, WE MUST LOOK AT BOTH MORTALITY AND MORBIDITY

1in10

patients develops a health care acquired condition (such as infection, pressure ulcer, fall, adverse drug event) during hospitalization.(b)

BUT WE MUST LOOK BEYOND HOSPITALS TO THE FULL CARE CONTINUUM



Roughly 1 billion ambulatory visits occur in the US each year.(c)

About 35 million hospital admissions occur annually.(c)

ADVANCEMENT IN PATIENT SAFETY REQUIRES AN OVERARCHING SHIFT FROM REACTIVE, PIECEMEAL INTERVENTIONS TO A TOTAL SYSTEMS APPROACH TO SAFETY(d)

1. Ensure that leaders establish and sustain a safety culture.
2. Create centralized and coordinated oversight of patient safety.
3. Create a common set of safety metrics that reflect meaningful outcomes.
4. Increase funding for research in patient safety and implementation science.
5. Address safety across the entire care continuum.
6. Support the health care workforce.
7. Partner with patients and families for the safest care.
8. Ensure that technology is safe and optimized to improve patient safety.

NPSF National Patient Safety Foundation®

To read the full report and detailed set of recommendations, visit www.npsf.org/free-from-harm

Basic Tenets of Human Error

- Everyone commits errors.
- Human error is generally the result of circumstances beyond the control of those committing the error.
- Systems or processes that depend on perfect human performance are inherently flawed.

Why Medical Errors Occur?

1. Given the conscientious nature of most typical health care provider and the comprehensive training he or she receives, why is it that health care is so dangerous?
2. “Errors are committed by good hardworking people trying to do the right thing.”

How Many Cars Do You See?

Too many things to track easily

Systems Thinking and Patient Safety

Because humans are fallible, we must rely upon systems and back-ups to prevent or detect errors before they can cause harm.

Swiss Cheese Model

Overview

- Current State of Safety
- Primary Care
- Interprofessional Solutions

Quality & Safety in Primary Care

- Patient safety events occur often in primary care
  - 1/20 patients experience diagnostic error in outpatient settings annually
  - Approximately 160 million medication errors occur annually in outpatient care
  - Communication breakdowns & transitions in care are frequent contributors to patient safety events

Settings by Engaging Patients and Families. Content last reviewed July 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/reports/engage.html

Errors in Primary Care

Safety Issues in Primary Care

- Vaccine Safety
- Medication Errors
- Polypharmacy
- Communication Breakdowns
- Diagnostic Test Follow up
- Inequality in Care Delivery
- Electronic Health Record Errors
- Diagnostic Errors

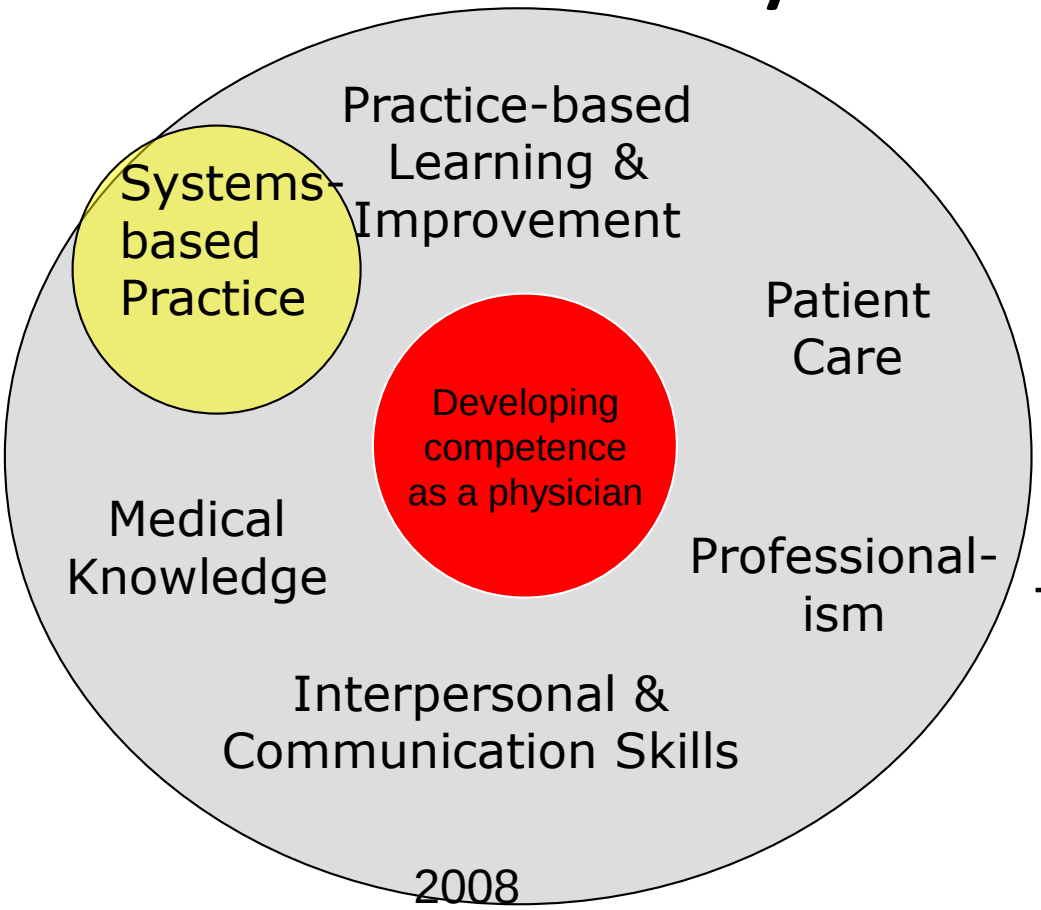
Overview

- Current State of Safety
- Primary Care
- **Interprofessional Solutions**

Medicine Response

- Safety Science integrated into every level of Medicine
- Hospitalists have special training

Safety in Medicine



2008

http://acgme.org/acWebsite/home/home.asp

Competencies

Patient Safety

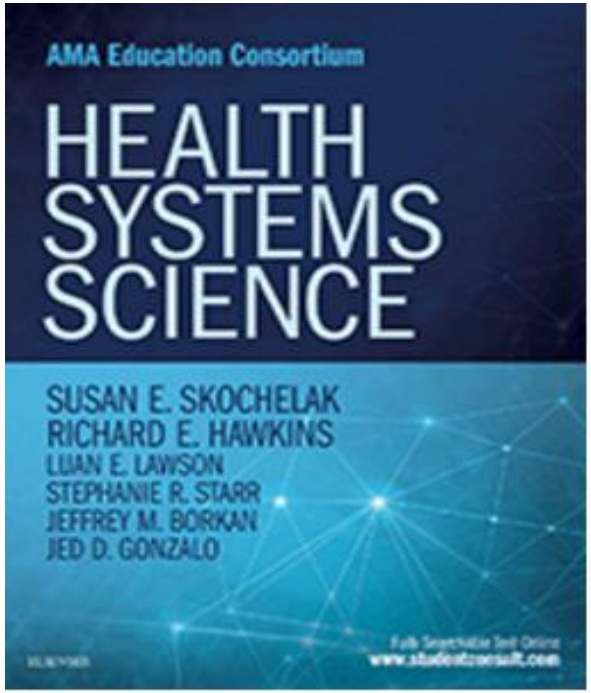
Quality Improvement

Health Equity

Patient & Family Partners

Teamwork, Collaboration, & Coordination

Medicine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STEPHANIE R. STARR
JEFFREY M. BORKAN
JED D. GONZALO

QSEN: Quality & Safety Education for Nurses

Goal of QSEN:

Provide comprehensive , competency based resources to empower nurses with the knowledge, skills and attitudes necessary to continuously improve the quality and safety of the healthcare systems in which they work.

QSEN Competencies

- **Patient-centered care**
- **Teamwork & Collaboration**
- **Evidence-based Practice**
- **Quality Improvement**
- **Safety**
- **Informatics**

***pre-licensure and advanced practice nursing 2005

QSEN Competencies

QUALITY IMPROVEMENT (QI)

Definition: Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.

KNOWLEDGE	SKILLS	ATTITUDE
s of care in the setting in which one is engaged in clinical practice	f care for populations served in care settingSeek information about quality improvement projects in the care setting	quality improvement is an essential part of the daily work of all health professionals
Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and familiesGive examples of the tension between professional autonomy and system functioning	Use tools (such as flow charts, cause-effect diagrams) to make processes of care explicitParticipate in a root cause analysis of a sentinel event	Value own and others' contributions to outcomes of care in local care settings
Explain the importance of variation and measurement in assessing quality of care	Use quality measures to understand performanceUse tools (such as control charts and run charts) that are helpful for understanding variation Identify gaps between local and best practice	Appreciate how unwanted variation affects careValue measurement and its role in good patient care
Describe approaches for changing processes of care	Design a small test of change in daily work (using an experiential learning method such as Plan-Do-Study-Act)Practice aligning the aims, measures and changes involved in improving care Use measures to evaluate the effect of change	Value local change (in individual practice or team practice on a unit) and its role in creating joy in workAppreciate the value of what individuals and teams can to do to improve care

Changing Safety Culture

Moving from a culture of

blame to a culture of safety……..

Culture of Safety

an atmosphere in which people are encouraged, even rewarded, for providing essential safety-related information - but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.

- Creating a learning culture
- Designing quality systems
- Managing behavioral choices

#1

Interprofessional Collaboration

SUMMON COURAGE
TO GIVE FEEDBACK & Receive
Feedback

We are all see the world differently……

Teamwork and communication

Goal:

- Pin your partner 5 times in the next 60 seconds

Domains of Relational Coordination

RC dimensions	**Survey questions**
1. Frequent communication	How *frequently* do people in each of these groups communicate with you about [focal work process]?
2. Timely communication	How *timely* is their communication with you about [focal work process]?
3. Accurate communication	How *accurate* is their communication with you about [focal work process]?
4. Problem solving communication	When there is a problem in [focal work process], do people in these groups blame others or try to *solve the problem*?
5. Shared goals	Do people in these groups *share your goals* for [focal work process]?
6. Shared knowledge	Do people in these groups *know* about the work you do with [focal work process]?
7. Mutual respect	Do people in these groups *respect* the work you do with [focal work process]?

#2 Be Innovative

DEFY TRADITION

ASK QUESTIONS

GET CURIOUS

Book: Josh Linkner
5 Obsessions of Innovators

Be Innovative

GET CURIOUS

Be Curious……..

Be Innovative

DEFY
TRADITION

Defy Tradition

Be Innovative

ASK QUESTIONS

https://www.youtube.com/watch?v=35LLuyfn5D4

Be Innovative

ASK QUESTIONS

Asking Why……

Real change does not come from decree, pressure, permission or persuasion.
Real change comes from people who are passionately and personally committed to a decision or direction that they helped to shape.

Margaret Wheatley

Berwick, D. M., Shojania, K. G., & Atchinson, B. K. (2015). Free from harm: Accelerating patient safety improvement fifteen years after To Err Is Human. *Boston, MA National Patient Safety Foundation*.

Brock, Douglas, Erin Abu-Rish, Chia-Ru Chiu, Dana Hammer, Sharon Wilson, Linda Vorvick, Katherine Blondon, Douglas Schaad, Debra Liner, and Brenda Zierler. "Interprofessional education in team communication: working together to improve patient safety." *BMJ Qual Saf* 22, no. 5 (2013): 414-423.

Carson-Stevens, A., Hibbert, P., Williams, H., Evans, H. P., Cooper, A., Rees, P., ... & Carter, B. (2016). Characterising the nature of primary care patient safety incident reports in the England and Wales National Reporting and Learning System: a mixed-methods agenda-setting study for general practice.

Donaldson, M. S., Corrigan, J. M., & Kohn, L. T. (Eds.). (2000). *To err is human: building a safer health system* (Vol. 6). National Academies Press.

Hewitt, T., Chreim, S., & Forster, A. (2017). Sociocultural factors influencing incident reporting among physicians and nurses: understanding frames underlying self-and peer-reporting practices. *Journal of patient safety*, *13*(3), 129-137.