NATIONAL GUARD HEALTH AFFAIRS

Quality & Patient Safety Newsletter

A QUARTERLY PUBLICATION OF THE QUALITY & PATIENT SAFETY COUNCIL VOLUME 4 / ISSUE 2 / Sep 2012

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Editor's Note:

I would like to thank everyone for the overwhelming support received for the re-launching of the Quality and Patient Safety Newsletter. We are especially grateful to those whose contributions made this initial issue a huge success. The numerous positive comments and feedback we have received regarding the new design and content has heartened us further to be steadfast in our mission to uplift the quality of care and patient safety in our esteemed institution, the National Guard Health Affairs.

In line with His Excellency, Dr. Bandar Al Knawy's vision for this newsletter to be a rich resource of quality and patient safety information, I am encouraging everyone to treat this journal as a bank that needs to be filled with useful and relevant articles that would benefit all healthcare and allied medical professionals in our organization. Articles can be submitted via e-mail to **qpsnewsletter@ngha.med.sa.**

It is my hope that more and more healthcare providers will engage in active discourse through this newsletter as we promote the culture of team-based collaboration in order to provide our patients with the optimum care that they rightfully deserve.

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Chairman, Quality Patient Safety (QPS) Council Committee
Editor-In-Chief, QPS Newsletter
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ABOUT THE NEWSLETTER

"By providing important and relevant information to healthcare providers, this Newsletter aims to enhance communication of quality and patient safety information, raise awareness of reported adverse events and maintain ongoing link to all the medical departments of the National Guard Health Affairs (NGHA) facilities. "

BUILDING SAFER CARE:

Leadership & Organizational Priority

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JCI Accreditation in Focus

The Journey for Accreditation, a Means not an End.....

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Accreditation: the certification of a program, service, organization, institution or agency by an authorized external body in accordance with predetermined criteria, usually expressed as standards, typically measuring structures and processes.

In developing countries, accreditation is increasingly being used as a tool for government regulation and healthcare organizations to guarantee quality of care.

At one time, preparation would start a few months in advance of pre-announced, scheduled surveys. Thereafter, compliance and surveillance fell off dramatically after these visits. This is no longer the case. Healthcare stakeholders are increasingly aware that quality isn't what it could or should be and are insisting that regulatory processes reflect the need for safe patient care 24/7/365.

One of the pioneered accreditation bodies is **The Joint Commission (TJC)**, formerly the **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**. It is a United States-based, independent, not-for-profit organization that accredits over 19,000 health care organizations and programs in the United States and far more outside the United States [Joint Commission International (JCI)]. The declared mission of the organization is "To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value". **JCI** Accreditation is considered as the golden standard for international medical facility credentialing and a landmark success that reflects an organization's commitment to meeting certain performance standards.

National Guard Health Affairs leadership decided to go through this endeavor with aims to provide high quality of care and patient safety. As a result, the first accreditation was granted in November 2006, through the enthusiasm and hard work of staff at all the NGHA facilities in the three regions. It was a major milestone in the NGHA journey towards better and safer patient care. Hence, the decision was to continue this journey through the second reaccreditation in December, 2009. We are due for the third reaccreditation at the end of the year 2012.

Continuous survey readiness isn't just the latest trendy term in accreditation process, it's become an imperative. Gearing up at the last minute for a Re-accreditation survey was never a very good idea, but with imminent changes coming in the survey process, it's more important than ever for our organization to be in a state of constant compliance with its standards. Hence, came the plan for the continuous readiness through various activities including unit based tracers, data management, and policy update and many other.

Being a JCI accredited organization is not an end in itself, rather a road-map to staying in the forefront of quality care in the Kingdom. JCI Accreditation is not a goal but a continuing journey towards excellent quality healthcare. Over the next few months we will continue to give you updates on the survey, results and citations, and further expatiation of standards and measurable elements.

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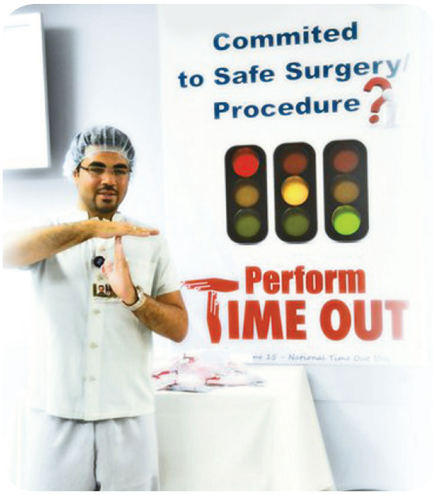

A LESSON LEARNED FROM REPORTED INCIDENTS:

Communication Saves Lives

Ms. Susan Al Owesie, RPh, CPHQ
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Communication Saves Lives:

Sara was a healthy 38 year-old wife, and mother of 3 children, complaining of stomach pain and frequent vomiting. She was diagnosed with an obstructed bowel due to non-malignant, non-life threatening symptoms. The woman was admitted in one of the reputable hospitals for a routine surgery under general anesthesia. Unfortunately, Sara died during the operation due to miscommunication between the surgical team. The surgeon had determined that the patient would be operated under general anesthesia and verbally communicated that decision to a nurse anesthetist, who failed to communicate clearly to the anesthesiologist. Ultimately, the anesthesiologist administered spinal anesthesia.

When the surgeon realized a spinal had been given instead of general, he decided to continue despite being unsure whether the spinal would last until the operation was complete. It did not. When the patient began to feel pain in mid-operation, the surgeon told the anesthesiologist to administer general anesthesia by mask. The anesthesiologist did so, but was unaware the operation was for an obstructed bowel, and failed to empty the patient's stomach or protect the patient's airway. Sara vomited large quantities of feculent matter into her lungs and subsequently died despite all the efforts to save her. Upon initiating Root Cause Analysis to identify "system failures", the surgeon mentioned that he thought the anesthesiologist was required to read the chart and know the purpose of the operation; the anesthesiologist, mentioned that she had relied on the surgeon to tell her what the operation was about.

Poor teamwork and miscommunication between OR team are critical to patient safety and had been determined to be the Root Cause for the death of Sara. Essential information about the patient`s condition and history of illness had fallen apart into black holes.

In a well-known study in 1999, the Institute of Medicine (IOM) reported that up to **98,000** people in the US died in one year alone due to medical error. The report attributes the high level of fatal mistakes directly to **miscommunication** or a **failure to communicate.**

Risk Prevention Strategies:

In the past, the notion existed that the surgeon was "captain of the ship" and responsible for the actions and omissions of all members of the team. Today, every member of the operating team is responsible for the patient's safety. Moreover, each member, even a non-medical member of an operating team, has the obligation to speak up if they notice something occurring that they believe may harm the patient.

Recently, the **"Surgical Safety Checklist"** which is adapted from WHO Surgical Safety Checklist was introduced to be utilized in the Main OR, Surgical Towers OR, OB/Gyne OR, Burns OR and Cardiac and Liver OR. The surgeon is supposed to take a "time out" and make sure that they are doing the right work on the right patient using the right instruments through the following elements:

1. Make sure it is the **correct patient** using two patient identifiers
2. Verify the **correct documents** (medical records, consent, radiological images, laboratory test results, etc.)
3. Mark the **correct site**, side, or level with the patient's / legal guardian's involvement
4. Verify **correct equipment** and **implants**, if needed
5. Conduct the "Time-Out" process, just before the surgery/invasive procedure, by way of final verification of the correct patient, correct procedure, correct site, and correct implants (if applicable) through active communication among all members of the surgical/procedure team.

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The power of knowledge in improving hand hygiene: truth or myth?

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The King Abdulaziz Medical City (KAMC) in Riyadh, has been actively engaged in the improvement of hand hygiene compliance for all healthcare workers since 2005. An approach that was adopted globally under the guidance of the World Health Organization (WHO) was implemented. Infection control personnel were trained on the well known 5 moments for Hand Hygiene (HH) and observations were conducted in all clinical areas for one year. During the pilot phase, HH compliance was monitored in adult ICUs during a baseline period and again during a follow up period; and the **implementation phase** where monthly and quarterly feedback of HH compliance was provided to the members of the observed department. A total of 1,658 HH opportunities were observed during the pilot phase and more than 55,000 opportunities were monitored over the next 2 years of implementation. Compared to baseline, rubbing increased (63.8% to 85.0%) while washing decreased (36.2 to 15.0%) during the follow up period ($p<0.001$). Baseline HH compliance rate was 45.3% and 76.1% thereafter. With an absolute improvement of 30.8% and relative improvement of 68.0%. The absolute improvement of compliance rate (average 30.8) was highest among nurses (34.6%) followed by other HCWs (28.0%) and finally doctors (21.9%). All HH indications had significant improvements with the exception of HH after body fluid exposure.

We continue to monitor HH and we have observed that education and feedback have impacted the compliance rates; but only to a certain degree. The initial improvement observed during the pilot phase of HH program at KAMC was maintained and actually improved. But we still have not reached our aspired 100% goal. We have also observed the difficulty of certain areas to improve on their rates, specifically acute care areas including the emergency wards. Creative and innovative strategies should be customized to help HCWs in these areas to improve on HH compliance, such as improving our understanding of patient and HCW flow, ease of access to the alcohol rub or sinks, re-identifying appropriate moments for these areas.

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Saudi Medication Safety Center: Partnering with Patients

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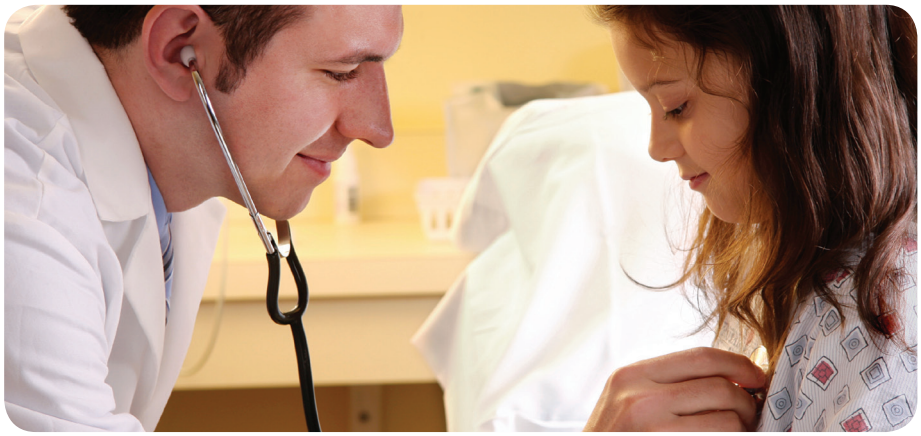

The patient is one of the most important allies in reducing medical errors. Research indicates that when patients actively participate in their overall healthcare management, medical errors are reduced. The foundation for a positive patient interaction is formed by establishing a partnership and creating a meaningful dialogue. Improving communications with patients, listening to their concerns, and facilitating active partnerships should be central to any patient safety strategy. Involving patients in the planning of health services also is recommended as a means of improving the quality of care. Additionally, several studies indicate that patient communication problems may account for an increase in medical professional liability actions.

Involving patients in the safety of their care has been suggested as a strategy for reducing medical errors for some time. Patient Centered Care (PCC) was lauded as a key element of quality in Crossing the Quality Chasm by the Institute of Medicine (IOM) in 2000. PCC respects and is responsive to individual patient preferences, needs and values, and ensures they guide all clinical decisions. Collaboration with patients and their families provides for more safeguards to be built into healthcare systems and processes. With several different perspectives that patients, families and clinicians can provide, safety improvement opportunities can be identified more quickly and effectively.

Patients have a key role in promoting their own safety. Patients are responsible for providing their healthcare team with the information that is necessary to reach an accurate diagnosis or treatment plan. In response, the healthcare worker (HCW) actively listens to engage the patient. The HCW can also solicit the patient's concerns and opinions by asking open-ended questions and asking patients to share key information, such as their medical histories (including illnesses, immunization and hospitalizations), medication history (including over-the-counter (OTC) medications, vitamins, dietary supplements, herbal / alternative medicines), and any allergies, reactions, or sensitivities experienced after taking medications / food.

According to an IOM report, "nearly half of all American adults have difficulty understanding and acting upon health information. The IOM defines health literacy as 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.'

Cultural barriers can also impede patient communication. Consequently, it is important for clinicians to use proven strategies to facilitate communications with patients, including:

- Speaking slowly and using plain, nonmedical language
- Limiting the amount of information provided and repeating the information; do not 'drown' the patient with information that may not be important for them
- Using teach-back or show-me techniques (asking the patient to repeat any instructions given) to confirm that the patient understands what has been explained
- Encouraging patients to ask questions
- Responding to patients' specific safety concerns
- Helping them make informed decisions in selecting medicines with benefit-risk profiles that are appropriate for them as individuals
- Providing written materials to reinforce oral explanations

Better informed patients:

- Know their family history and its relation to their own health; thereby, play a greater role in their healthcare
- Know their medical conditions and treatment options, and participate more in decision making
- Keep their healthcare team fully informed about their health and medication history
- Follow agreed treatment regimens
- Ask questions until they understand
- Lessen their anxiety
- Have more realistic expectations
- Report their adverse event experiences to the healthcare professionals treating them

This is your Newsletter and we value your comments. Please recommend Quality Improvement Projects in your area. We strongly encourage you to share patient safety information.
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- Take notes on what is learned in the doctor's office and pharmacy. Bring support when accessing healthcare
- Expect open and honest communication

As medication errors are the largest source of preventable adverse events, there are a number of questions every patient should ask before taking medications:

- Is this the medicine my doctor (or other healthcare practitioner) ordered for me? What does the medicine look like?
- What is the name of the medicine? Is this the brand or generic name?
- What is the purpose of the medicine? What is it supposed to do? When should I expect the medicine to work, and how will I know if it is working?
- How and when am I to take this medicine? For how long? What do I do if I miss a dose?
- What are the side effects of this medicine? What do I do if they occur?
- Is this new medicine safe to take with my other medicines, including over-the-counter and dietary supplements?
- What activities, food, drinks should I avoid while taking this medicine?
- Can I get a refill of the medicine? When?
- How should I store this medicine?
- Is there any written information available about the medicine? (Is it available in large print or a language other than English?)

Patients and family members, who speak up about patient care issues, have not only identified medical errors but have also prevented errors and injuries. Following are just a few examples of such reports in the literature:

- A Nurse was providing education to a patient and spouse prior to flushing a PICC line. When the Nurse mentioned Heparin, the spouse spoke up and said the patient was allergic to Heparin. The Nurse reviewed the chart and found no Heparin allergy documented. The allergy had been documented on the patient's transfer record and had not been transcribed onto the chart. New orders were obtained for flushing the patient's PICC line using Normal Saline only.

In most instances, when patients speak up, clinicians listen and take appropriate action. However, sometimes an error still occurs despite the opportunity for recovery provided by a patient's attentiveness and communication. Medical errors may occur when a patient or family member does not understand medical terminology.

- A patient with a dye allergy was ordered a CT scan with contrast. "No allergies" was noted on the admission orders. The allergy was noted on the MAR, but not on the Patient Care Kardex. The Nurse asked the patient if he had an allergy to "contrast" but the patient said "no" because he did not realize that the term meant IV dye. The patient was started on the contrast infusion and only later reported the allergy.

This occurrence may have been prevented if lay terms had been used instead of professional terminology.

There are some reports of errors which occurred because the patient's concern may have been minimized or dismissed:

- A Phlebotomist came to the incorrect patient's room to draw blood for cardiac enzymes. The patient asked why she was having the blood drawn when her diagnosis was kidney stones and she had already had blood drawn that morning. The Tech said to the patient that she didn't know why and drew the blood anyway, even though a patient ID band and name tag above the bed were present.

Sometimes such errors occur because the healthcare worker is busy caring for many patients. The focus may be upon accomplishing a multitude of tasks and sensory overload may occur. As a result the patient's words may not be heard. Another potential contributing factor may be the traditional model of healthcare workers. This is a dominance-subordination (parent-child) model in which clinicians are considered the experts and the primary decision makers regarding the patent's care. In this model, patients are expected to be passive and compliant, supplying information when asked, and following through with the healthcare professional's advice.

This dominance-subordination medical model subverted patient care by discouraging collaboration. Communication is inhibited and the potential for patient involvement in patient safety is prevented. Collaboration with patients and their families provides for more safeguards to be built into healthcare systems and processes.

Many reports in the literature also indicate that instead of ignoring the patient, the patient's word is too hastily accepted as accurate. This can result in an error when the patient's information is not independently verified prior to an intervention:

- A patient was scheduled for a right shoulder open reduction and internal fixation (ORIF). The Anesthesiologist asked the patient if she was having surgery on her left shoulder, to which the patient replied, "Yes". The Anesthesiologist performed an intrascalene block on the left shoulder. After the block was administered, the Nurse informed the Anesthesiologist that the surgical consent was for a right shoulder ORIF. Having a time out protocol that requires all surgical team members to be present for site verification and having a process in place for the patient to identify the surgical site may have prevented this occurrence. Also, avoiding the use of leading questions may have avoided this event (i.e., asking which site was to undergo surgery, rather than designating a specific site in the verification question).

Educating patients to become knowledgeable about their healthcare needs and to assume active roles when interacting with healthcare professionals promotes more effective and efficient care and may help to prevent medical errors. Patients who feel powerless under the traditional medical model do not automatically become empowered; however, partnering with patients to improve communication results in increased patient satisfaction, increased diagnostic accuracy, enhanced adherence to therapeutic recommendations, and improved quality of care.

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Disclosing adverse events to patients

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The prevalence of medical errors is a significant and ongoing problem. Despite best efforts, medical errors continue to occur. Disclosure of adverse events to patients is morally and ethically necessary to achieve the optimal goal of respecting patient rights.

This practice is consistent with the following **Joint Commission International Accreditation standards:**

1. **PFR. 2.1.1** The organization informs patients and families about how they will be told about the outcomes of care and treatment, including unanticipated outcomes, and who will tell them.
2. **COP.2.4** Patients and families are informed about the outcomes of care and treatment, including unanticipated outcomes.

Regardless of whether they are preventable or unpreventable, adverse events represent extreme uncomfortable reality of medical care. Studies show that in the event of an adverse outcome, patients expect and want timely and full disclosure of the event, an acknowledgement of responsibility, an understanding of what happened, expressions of sympathy, and a discussion of what is being done to prevent recurrence. Thus, health care providers should understand how to best disclose and discuss adverse events with patients and their families.

There are many steps in the disclosure process. The Harvard framework for disclosure provides a quick reference for clinicians to disclose adverse events to patients and families.

Framework for Disclosure
Preparing

- Review the facts
- Identify and involve the appropriate participants
- Use an appropriate setting

Initiating Conversation

- Determine patient and family readiness to participate
- Assess the patient and family's medical literacy and ability to understand
- Determine the patient and

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family's level of medical understanding in general

Presenting the Facts

- Simple description of what happened
- No medical jargon
- Speak slowly
- Be aware of body language
- Do not overwhelm with information or oversimplify
- Explain what is known of the outcome at that point
- Describe the next steps
- Sincerely acknowledge the patient's and family's suffering

Actively Listening

- Allow ample time for questions
- Do not monopolize the conversation

Acknowledging What You Have Heard

Responding to Any Questions

Concluding the Conversation

- Summarize
- Repeat key questions raised
- Establish the follow-up

Documentation

- Describe the event
- Describe the discussion

Always remember the key principles of open disclosure

- Openness and timeliness of communication
- Acknowledgement of the incident
- Expression of regret/ apology
- Recognition of the reasonable expectations of the patient and their support person
- Support for staff
- Confidentiality

Additional Resources

The following resources provide more guidelines to assist clinicians through the disclosure process:

- Crafting an effective apology (Joint Commission Resources)
- Open disclosure (Australian Commission for Safety and Quality)
- Open disclosure guidelines (New South Wales, Health Australia)
- Disclosure of adverse event (Department of Veteran Affairs)
- Communicating with your patient about harm (The Canadian Medical Protective Association)
- When things go wrong: responding to adverse events (Consensus Statement of the Harvard Hospitals)
- Disclosure: The next step in better communication with patients (American Society for Healthcare Risk Management, part 1 of 3)
- Disclosure: Creating an effective patient communication policy (American Society for Healthcare Risk Management, part 2 of 3)
- Disclosure: What works now and what can work even better (American Society for Healthcare Risk Management part 3 of 3)