NATIONAL GUARD HEALTH AFFAIRS

Quality & Patient Safety Newsletter

A QUARTERLY PUBLICATION OF THE QUALITY & PATIENT SAFETY COUNCIL VOLUME 5 / ISSUE 2 / June 2013

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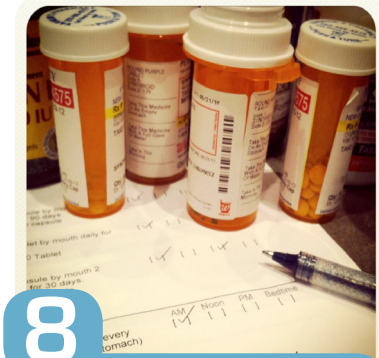

ABOUT THE NEWSLETTER

"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. "

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JCI Accreditation In Focus:

OUR JOURNEY CONTINUES: POST- JCI RE-ACCREDITATION SURVEY

Ms. Jani Hafez , QM Specialist, Quality Management Department -WR

Have you wondered how the surveyors score the standards, and how they arrive at the ultimate accreditation decision?

On the final day of the survey, an exit interview is held with the organization's CEO/Executive Directors, and other leaders. The Surveyors complete their findings and leave a copy of the findings with the CEO/Executive Directors. Standard scores that NGHA disagrees with may be appealed, and filed with JCIA with documentation that proves inaccuracy.

Scoring the Survey Results

Each Measurable Element (ME) is scored
– Met (10)
– Partially Met (5)
– Not Met (0)

All Measurable Elements are averaged to obtain the score for the standard
All Standards are averaged to obtain the score of the Chapter
All Chapters are averaged to obtain the Overall Score

Accreditation Decision

- The organization demonstrates acceptable compliance with each standard. Acceptable compliance is:
  – A score of at least "5" on each standard
- The organization demonstrates acceptable compliance with each Chapter. The International Patient Safety Goals are considered a Chapter. Acceptable compliance is:
  – An aggregate score of at least "8" for each Chapter of Standards.
- The organization demonstrates overall acceptable compliance. Acceptable compliance is:
  – An aggregate score of at least "9" on all Standards.
- The total number of measurable elements found to be "not met" or "partially met" is not above the mean (three or more standard deviations) for organizations surveyed under the organization accreditation standards within the previous 24 months.

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JCIA Communication

Ten (10) days after receipt of the surveyors' report, JCI notifies NGHA whether a focused repeat survey or other follow up condition will be required. If a focused resurvey or other follow up condition is not required, NGHA will be notified that a Strategic Improvement Plan (SIP) must be submitted for each Measurable Element that received a score of "Not Met" and for those "Partially Met" specified by JCI.

Strategic Improvement Plans (SIP)

A Strategic Improvement Plan (SIP) is a required written plan of action that NGHA develops in response to "not met" and "partially met" findings identified in the JCI Official Survey Findings Report 2012. The written SIP is expected to:

- Establish the strategies/ approach that NGHA will implement to address each "not met" finding;
- Describe specific actions that NGHA will use to achieve compliance with the "not met" standards/measurable elements cited;
- Describe methodology to prevent reoccurrence and to sustain improvement over time; and
- Identify the measure that will be used to evaluate the effectiveness of the improvement plan

Due date of the SIPs is 45 days after notification. JCI will evaluate the SIPs for adequacy. The SIP must demonstrate that NGHA's actions lead to implementation of **"SUBSTANTIAL and SUSTAINABLE"** measures necessary to achieve full compliance with the standards and measurable elements.

JCI defines **sustainable** as: the ability to maintain a certain process or state that can continue to produce the targeted compliance results.

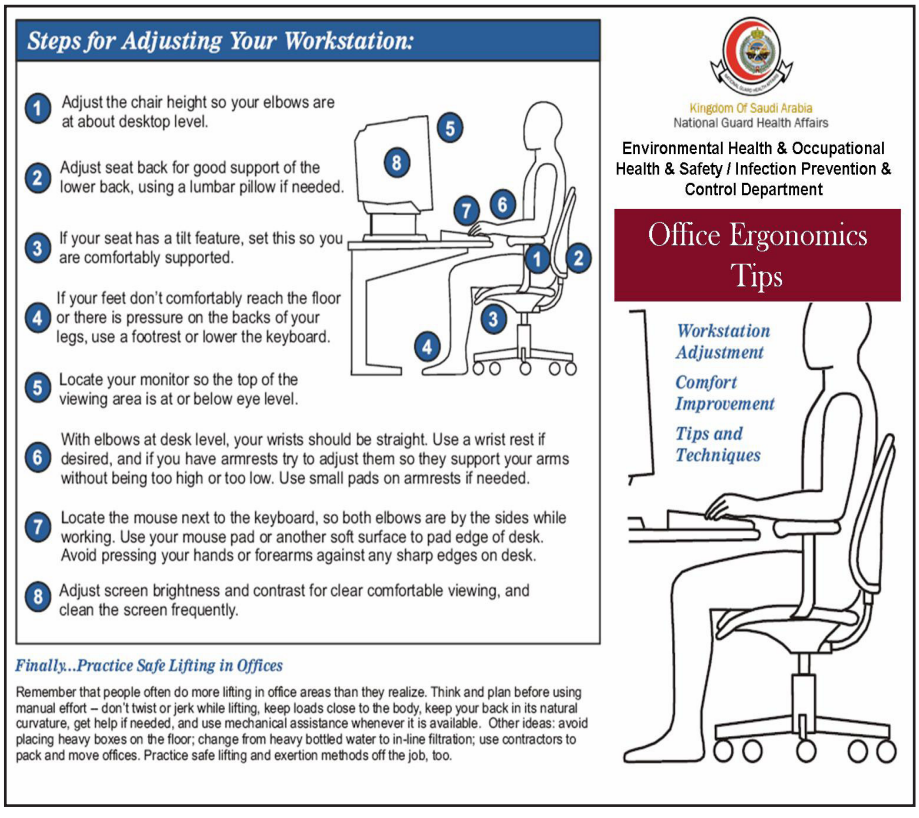
JCI uses the following criteria to determine the acceptance of the SIP:

- The plan meets the JCI Accreditation standards intent and requirement.
- The plan will be implemented within the appropriate timeframe to address the severity of the cited findings.
- The plan considers using clinical standards, scientific literature, and other evidence-based information.
- The plan addresses patient care processes and systems related risk when appropriate.
- The plan addresses findings from organization-wide or system perspectives, when appropriate.
- The plan will be evaluated to measure the organizations ongoing performance overtime.

If the decision is that they are not all adequate, JCI will notify NGHA to resubmit the SIPs to meet the above criteria. Failing to submit an acceptable Strategic Improvement Plan (SIP) within 120 days of the survey may place NGHA at risk for denial of accreditation.

What Does JCI Re-Accreditation mean?

It means that NGHA will continue on its journey towards enhancing a patient safety culture and provision of high quality care by creating an environment that is patient-centered, transparent, and focused on improvement at all levels.



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Raising a Red Flag: Report a Near Miss

Dr. Tamer Farahat
Director, Quality Management, Al Ahsa, Eastern Region

The odds are greater that a person will be injured or die as a result of medical error than as a consequence of driving or flying. The Canadian Adverse Events Study estimated that 7.5% of patients admitted to acute care hospitals in Canada in 2000 experienced 1 or more adverse events. The study found that 36.9% of these patients had experienced highly preventable adverse events.

Culture change is essential to improve patient safety. In an effort to have this shift in culture, the health care system must make a transition to a new culture of safety. In this new culture; the belief is that most errors and near misses occur because of flawed systems, not flawed people. Reporting a near miss provides another opportunity for organizations to learn about system vulnerabilities and prevent future errors. These are the heart-sinking situations when you realize, just in time, that a significant mistake almost occurred that could have adversely affected patient care. Alternate terms for near misses are: near error; near hit; potential adverse event; close call; and good catch. A near miss is a free lesson in proactive risk management and error prevention. Research shows that for every 600 near misses, there are 30 minor incidents, 10 major incidents and 1 critical incident (involving serious property damage, major injury or death).

Numerous studies define near misses as occurrences that could have harmed the patient but did not cause harm as a result of chance, prevention, or mitigation. According

to the Canadian Council on Health Services Accreditation, a near miss is an event or circumstance which has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but did not actualize due to chance, corrective action, and/or timely intervention. Association for Healthcare Research and Quality define near miss as an event or situation that did not produce patient injury, but only because of chance. This good fortune might reflect robustness of the patient (e.g., a patient with penicillin allergy receives penicillin, but has no reaction) or a fortuitous, timely intervention (e.g., a nurse happens to realize that a physician wrote an order in the wrong chart). This definition is identical to that for close call. The Institute of Medicine defines it as an event in which unwanted consequences were prevented.

Although, several classification schemas have been developed for adverse events or errors, but less attention has been paid to classifying near misses in health care. Currently there is a lack of clarity and consensus regarding what constitutes a near miss occurrence in health care.

Near misses are daily occurrences in the health care sector simply because health care professionals are human. Human factors that leads to errors such as lack of experience, skill or motivation that inhibit a person's ability to perform well. Furthermore, the impact of these factors is magnified when the person is fatigued, stressed or distracted, all of which tend to be magnified during a crisis.

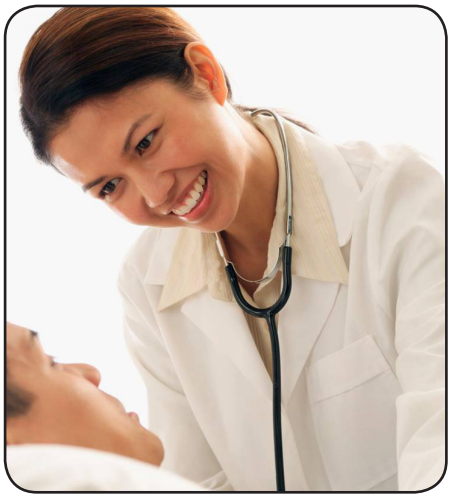
In hospitals and health care systems, incident reporting is the primary means through which adverse drug events and other risks are identified. The organization must capture the interest of all staff and use this momentum to improve the patient safety culture in their institution. Reporting methods should foster an environment where compliance with reporting and proactive monitoring of near miss events makes patient safety the focus of staff efforts.

Anonymous self-report methods provide a means by which the person committing or witnessing an error can report the mistake without being associated with it. The advantages of this method are its low cost and the ability of staff to avoid the fear of disciplinary action. However, anonymous reporting may not be feasible in all institutions, but is a great method to improve reporting as near miss reports cannot be assigned blame to any one individual.

When non-punitive reporting system has been implemented in healthcare work environment, reporting of errors and near misses increased dramatically, and improvement in the safety of care delivery has been enabled.

No matter what the method of reporting near misses, all members of the health care team need to be aware that through reporting they are making a positive contribution to the creation of a high reliability environment.

The purposes of reporting are to: improve the management of an individual patient; identify and correct systems failures; prevent recurrent adverse events; aid in creating databases for risk management and quality improvement purposes; assist



in providing a safe environment for patient care; provide records of the events; and if necessary, obtain immediate medical advice and legal counsel.

A review of the literature confirmed that health care professionals do not report near misses for a number of reasons: lack of understanding; fear; blame; belief that reporting may not result in improvement; lack of feedback; and complaints about available reporting systems. Staff may think if no harm occurred, there is no need to report the incident.

A formal program of recognition and reward not only encourages reporting, but reduces the fear of punishment, especially when the near miss is apparently a result of an error or lapse by the individual who initiates the report.

Near misses are as important to report and prevent as errors. Research has shown that the more incidents that are reported the more information is available about any problems and the more action can be taken to make healthcare safer. It is not realistic to think that all near misses can be reported; but increasing the number reported can improve patient safety.

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Common Cause Analysis (CCA): Optimizing Your Solutions for Your Own System

Souzan M. Al Owais, Rph, CPHQ
Quality Management Specialist
Quality Management Department, KAMC-R

Sentinel Events or serious errors involving death or significant patient harm are usually investigated and addressed through the well-known Root Cause Analysis (RCA) process. RCA is performed in response to a single safety event and is resulting in an overwhelmingly list of improvement actions. Furthermore, RCA Lacks of the big-picture view, which means that it may not reveal deeper themes and more common causes of patient safety events that affect other similar hospital areas and departments.

In view of the aforementioned challenges and far more with the RCA process, some organizations started to utilize a different- less well known approach—Common Cause Analysis (CCA). This type of analysis is used mostly with "low risk incidents" and near misses, which do not necessitate immediate attention and corrective actions. Also, CCA has been utilized to summarize findings and actions of collective RCAs and/ or shared themes RCAs on annual basis (1). Furthermore, aggregating various data from FMEAs, infection control findings, mini-RCA are also considered rich source for Common Cause Analysis that identifies system vulnerabilities (Figure 1)

Common cause analysis (CCA) doesn`t target a single event as the case in RCA. However, it aggregates data from multiple incidents` variances and contributing factors to identify the common causes of those events (See Table 1. Major differences between RCA and CCA). Once common themes related to the local system are identified, specific actions and solutions (from within the local system or in the literature) are listed to target each theme.

Aggregating and trending data is always more efficient in preventing recurrence of events than single-event root cause analysis (2). Good RCA process reduces event rates for serious events of patient harm by 50% in 2 years. A Common Cause Analysis of all cases produces similar results, however, with one-tenth of the resources required (2). As the case with most of the quality and safety processes and tool, healthcare was lagging behind other high-risk industries in adapting CCA for incidents analysis. CCA has been successfully applied in aviation and nuclear power industries to identify multiple failures of components with shared common root causes (3).

Few healthcare researches have studies this tool so far, but the potential for results is enormous in that less-significant events can be used to improve patient safety before an event of serious harm occurs.

Recently, National Guard Health Affairs has launched and rolled-out the new version of the Electronic Safety Reporting System (SRS) onto all NGHA regions. We are expecting tremendous increase in the incidents reporting rate. Hence, it might become essential to explore and adapt CCA process to cope up with the review, analysis and management of anticipated huge number of reported incidents.

Common Cause Analysis is not going to be an easy task, especially in the beginning, but the potential results is enormous in that less-significant events (precursor) can be used to improve patient care before an actual serious event occurs. Lastly, it is worth mentioning that in alignments with the recent healthcare systems` call to consider the context in applying different tools and evidence-based processes, CCA shall allow an organization to identify the depth and breadth of its owns system vulnerabilities (4).

Figure (1). Common Cause Analysis data sources to identify system vulnerabilities

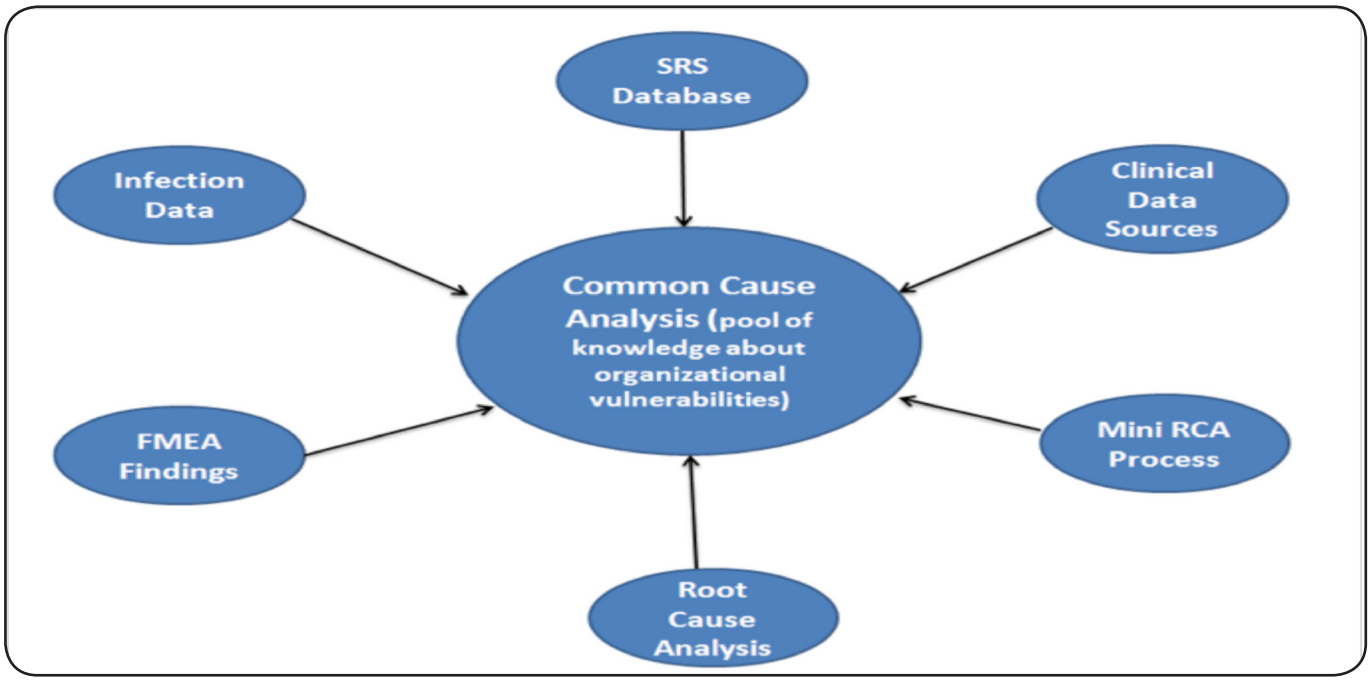

Table 1. Major Differences between RCA and CCA

Root Cause Analysis (RCA)	Common Cause Analysis (CCA)
Single Case or a few related cases.	Many or all cases
Event directed (examines a single event or adverse trend of related events).	Time or trend directed (examines all cases in a time period)
Efficient for diagnosing process, protocol, and technology causes.	Efficient for diagnosing people, leadership, and environment of care causes.
Investigates cause-and-effect relationships directly	Infers cause
An effective program lowers rates of serious harm by 50% every 2 years.	An effective program lowers rates of serious patient harm by 50% every 2 years, with 10% of the resource allocation of root cause analysis.

Adapted from OhioHealth Case Study (2)

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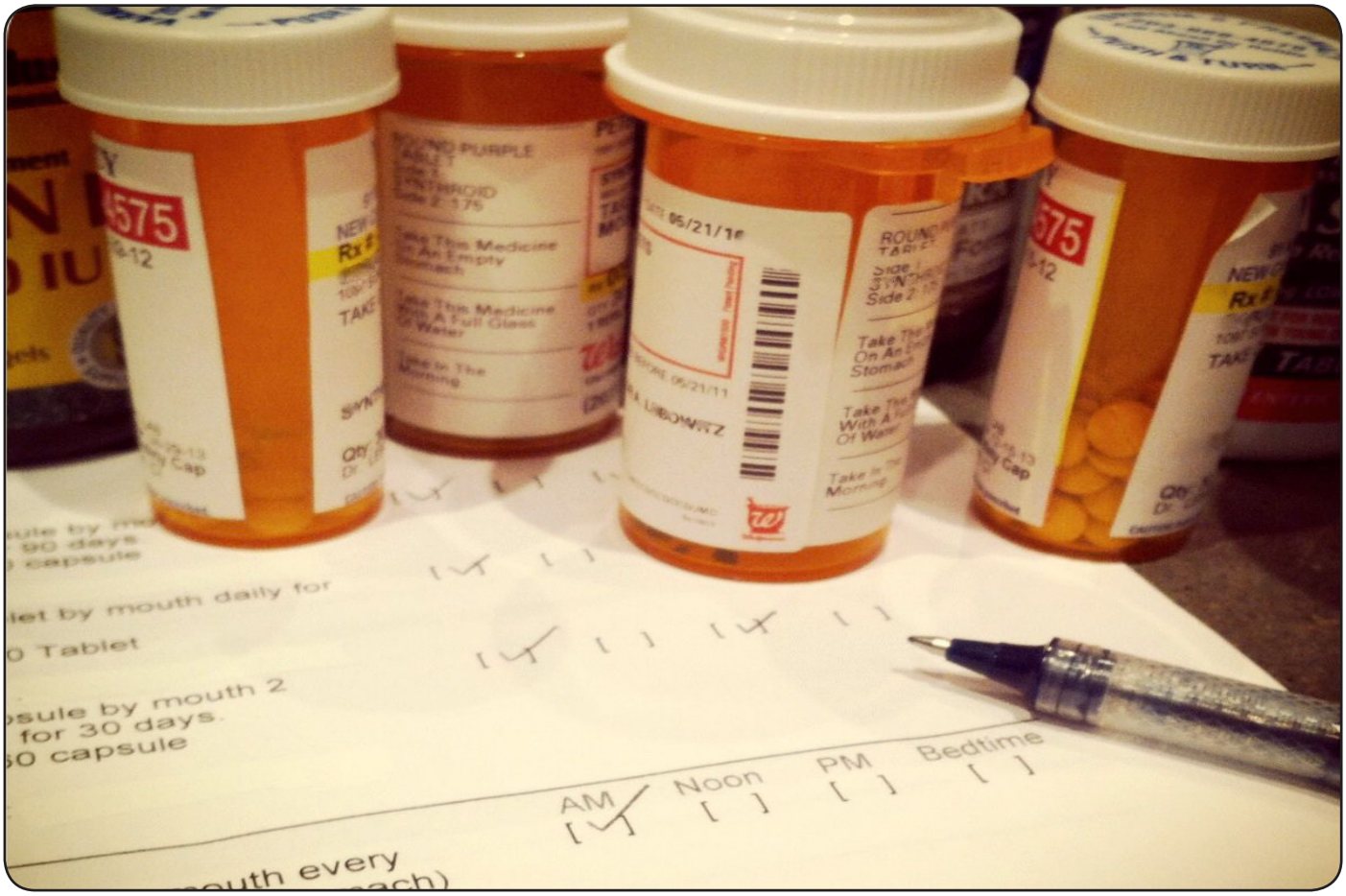
Saudi Medication Safety Center:

Discharge Medication Counseling

Dr. Gregory A. Poff, Chairman
Saudi Medication Safety Center (SMSC)



Counseling patients is an important part of the discharge process. Medication error databases are full of events, including fatalities, that could have been prevented had the healthcare provider counseled the patient regarding the use of the medications. Some of these errors are directly related to wrong drug, dose, or dosage form or providing the wrong directions for use.

By reviewing the prescribed medication's indication, dose, and directions for use with the patient, the healthcare provider can discover anything that does not match what the Prescriber told the patient. Opening the prescription bottle or box gives the patient an opportunity to see the medication and speak up if it looks different than expected.

Counseling can also avert patients' mistakes in medication use, such as concomitant use of the same medication with two different trade names. Counseling is especially important with new prescriptions for High Alert medications or medication for high-risk patients (e.g., the elderly (greater than 65 years of age), patients prescribed four or more scheduled medications, pediatric patients).

Simply asking the patient, "Do you have any questions?" is not enough. At first patients may dislike having to wait another few minutes, but in the long run they will appreciate the benefit, realizing that an educated patient (or caregiver) is the final safety check in preventing medication errors.

Below is a 'Simple Step-by-Step Guide' for any healthcare provider to use when performing Discharge Medication Counseling. It can be adapted as the basis for an in-service program for new staff / students, as well as, be used by healthcare providers as a simple check-list in their daily patient care activities.

To reiterate: Simply asking the patient, "Do you have any questions?" is not enough.

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DISCHARGE MEDICATION COUNSELING

Simple Step-by-Step Guide

This simple step-by-step guide is a resource for you to better understand what the discharge medication counseling session might entail and enhance your skills in counseling.

STEP 1: Preparation

- Gather the discharge order and discharge medications.
- Ensure correct drugs are dispensed for the correct patient by cross checking the discharge orders, drug packaging labels, and actual medication names.

STEP 2: Information Gathering

- Review the patient's reason for admission.
- Review appropriate laboratory results.
- Reconcile the discharge orders with the Admission Medication Order Sheet (APF).
- Evaluate discharge medications for:
  - Appropriateness of drug, dose, frequency, and route of administration
  - Therapeutic duplication
  - Allergies or sensitivities
  - interactions between the medications and or food

STEP 3: Establish Rapport

- Greet patient.
- Introduce yourself.
- Explain the purpose and ask permission.

STEP 4: Patient Identification (International Patient Safety Goal 1: Identify Patients Correctly)

- Ask patient to state his/her full name. If the patient is a child or unable to verbalize, ask the family member to state the patient's full name.
- Check the ID band for correct MRN and Name.

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STEP 5: Counseling Techniques

The best technique for counseling is a combination of How and Tell and the Prime Questions.

For Refill Medications: - How & Tell Questions

- What do you take this medication for?
- How have you been taking it?
- What kinds of problems are you having with it?

For New Medications: - The Prime Questions

- What did the doctor tell you the medication is for?
- How did your doctor tell you to take the medication?
- What did the doctor tell you to expect?
- How long to take the medication?
- Exactly how much or how often to take it when the medication is prescribed as needed?
- What to do when a dose is missed?
- How to store the medication?

STEP 6: Strategies to Address and Improve Adherence

- **Suggest the use of pillboxes and calendars.**
- Use a probing statement following the "I noticed/I'm concerned'' formula.
- Listen for clues that may indicate the patient is reluctant to take the prescription.
- Link medication taking to a daily activity.
- Suggest that medication be kept where it is easily seen.

Note:
Always open the medication containers and show patient what the medication looks like or demonstrate use.

STEP 7: Closing

- Thank the patient.
- Ask the patient if he/she has any questions.

STEP 8: Documentation

- Document the patient counseling in the Interdisciplinary Patient Education Record (IPER) Form of the patient's file.

PREPARED BY:
Medication Safety Program – WR

PATIENTS Partners of Care

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.
Secretariat: Office of the Chief Medical Officer (MC2211) P.O.Box 22490, Riyadh 11426 KSA
Email: qpsnewsletter@ngha.med.sa
Contact No. 01 8 0 11111 X 43518 Fax No. 01 80 11111 X 43333