AAAHC

Connection

Timely information for best practices

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Patient Safety and Healthcare Quality

The famous quote attributed to Hippocrates (ca 400 BC), “first do no harm,” illustrates that the issue of patient safety has a long foreground. It’s a formative idea, a foundational principle, in the development of a culture of safety, one that places safety and well-being as primary components of all provider-patient encounters. As an accrediting body, AAAHC considers this issue as critical to the mission of improving healthcare for all. Guidelines for patient safety are present throughout the Standards and can be found in chapters 5-II, “Risk Management,” and 7-II, “Safety,” among others.

In November 1999, IOM released, *To Err is Human*, a report which challenged over-ripe assumptions about patient safety. Previously held approaches used investigation and resolution of medical errors as a process of looking for the guilty party, the assigning of blame to one cause which was then

addressed with disciplinary action, termination, and/or the law. The thinking was that once the humar error was eliminated, further problems would be prevented.

What IOM found and what most causal analyses confirm is that, typically, effects/results/consequences are created by multiple factors rather than a single cause. As data were compiled and the evidence-based study of patient safety grew, researchers found that medical events are usually the result of system, not personal, breakdown—a series of failures, not one. This approac turned the focus from assigning personal blame or liability to an examination of a breakdown within the system involving a set of contributing factors which combined to create the adverse event.

As cognitive scientist, Don Norman, observes in The Design of Everyday Things, "People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."

The second perspective resulting from this more attuned (closer) look at patient safety is that healthcare can learn from events and “near misses” or “close calls” (an illness/injury was “just” averted) and develop and employ preventive measures. Using the “near miss” as a teachable momer addressed through a systems analysis approach affords the opportunity to see multiple places in the chain of events that could lead to a breakdown. From this perspective, “near misses” offer opportunities for exploring contributing factors and implementing potential safeguards.

So, what needs to be done to enhance the culture of safety within an organization?

Since staff encounter potential adverse events, there needs to be an openness about sharing this information, one which encourages reporting. “Near misses,” “never events,” and the like should not strike fear into the individuals involved but should empower staff to report them and contribute to the conversation on how to prevent them in the future—all without fear of retribution. Assigning staff to coordinate activities and to educate their colleagues is a team-building opportunity that seeks collaboration and buy-in from all levels of an organization. The Agency for Healthcare Research and Quality (AHRQ) identifies teamwork training, executive walk arounds, and establishing unit-based safety teams as initiatives which have been associated with improvements in safety culture measurements and lower error rates.

For healthcare, one of the most important industry examples of reporting systems for near misses or events is aviation. Pilots who have difficulty with a confusing new runway layout report the issue. The problem becomes clear very rapidly and known mechanisms (reconfiguring or using lighting and other warnings) can be put in place to prevent problems (collisions). Pilots are not penalized for reporting (admitting that they’re confused or went on the wrong runway); reporting systems save lives In medicine, reporting systems lead, for example, to changing packaging of high concentration IV solutions, so they cannot be directly connected to IV drips. This is a result of a “culture of communication” operating within a larger “culture of safety.”

From an operational point of view, risk management is part of a safety program. Checklists are a useful tool in monitoring safety (see the AHRQ safety culture checklist below), however, by

themselves will not create a “culture of safety.” Looking at trends from safety inspections and sharing safety concerns among staff lead to greater awareness within the organization of activities in need of improvement.

A patient safety culture tool checklist (adapted from AHRQ for ASCs)*

- ☐ Raise staff awareness about patient safety (through education and open discussion of safety issues).
- ☐ Diagnose and assess the current status of patient safety culture.
- ☐ Identify strengths and areas for patient safety culture improvement.
- ☐ Examine trends in patient safety culture change over time.
- ☐ Evaluate the cultural impact of patient safety initiatives and interventions.
- ☐ Conduct internal and external comparisons.

* Krizirian, S. “The Importance of Creating a Culture of Patient Safety at Surgery Centers.” Becker’s ASC Review. https://www.beckersasc.com/asc-accreditation-and-patient-safety/the-importance-of-creating-a-culture-of-patient-safety-at-surgery-centers.html. Accessed October 6, 2017.

Resources for patient safety

The growing library of AAAHC Patient Safety Toolkits includes titles, such as Safe Injection Practices Flexible GI Endoscope Reprocessing, and Care Coordination: Tracking Patient Tests and Referrals. Browse our line of toolkits here.

Quality Improvement Insights

AAAHC Institute Quality Improvement Insights is a resource that ambulatory health care providers ca use to better understand important quality improvement (QI) topics. Topics covered include, but are not limited to, benchmarking, patient safety, and the “10 elements” of QI. This publication also includes a Patient Safety Toolkit on Emergency Drills. Learn more here.

Orthopaedic Certification

Coming soon! AAAHC will roll out the new Orthopaedic Certification program. Contact orthopaedic@aaahc.org for information.

Upcoming educational programs

Achieving Accreditation will be held in Las Vegas, December 1-2, 2017 and in Tampa, FL, March 16-17, 2018. Register here for the program that includes the 2018 Standards.

Contact Us

AAAHC
5250 Old Orchard Road Suite 200

Skokie, IL 60077
P: 847.853.6060 F: 847.853.9028
info@aaahc.org

www.aaahc.org