



الجمعية السعودية للعلاج الطبيعي
Saudi Physical Therapy Association

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Patient Safety

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Leadership walk-round



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Safety WalkRounds

- A “Safety WalkRound” is a process whereby a group of senior leaders visit areas of a health-care organization and ask front-line staff about specific events, contributing factors, near misses, potential problems, and possible solutions.





Leadership round rules

- 1) Should be **preparation** from leadership and unit participants .
- 2) Should consist of : leader, scribe , pso , quality professional and director of the unit .
- scribe** : person who capture comments , concerns and safety events .
- 3) Walk-around should be scheduled based on **staff schedule** not **leader schedule** .
- 4) **In the morning and after shift change** not a good time due to care for patients
- 5) Should occur in **all shifts** due to all staff has **opportunity to speak up**
- 6) Should occur weekly for at least a year to reinforce to staff that commitment of leadership not a one time occurrence.
- 7) **Manager of unit** should know several days in advance that walk- around will be done .
- 8) Important to take **a camera** along walkaround
- 9) **Feedback** should be given to the staff

Patient Safety Leadership Rounds

- The WalkRounds should consist of a senior leader, a scribe, the Patient Safety Officer and/or Quality Professional, and the manager/director of the unit.
- The scribe captures comments, concerns, and safety events.



SAFETY

MATTERS



Patient Safety Leadership Rounds

- WalkRounds cannot simply start without preparation of senior leadership and unit participants.
- The manager of the unit/department should know several days in advance that the WalkRounds will be done on that unit/department.





Patient Safety Leadership Rounds

- The WalkRounds should be scheduled based on the **staff's schedule** and not the leaders' schedules.



- The WalkRounds should occur on **all shifts** so that all staff members have opportunities to voice their concerns.



Patient Safety Leadership Rounds

- The WalkRounds should occur

weekly for at least a year to

reinforce to the staff and others

that the commitment from the

leadership is not a one-time

occurrence.

WEEKLY CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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COMMITMENT





Patient Safety Leadership Rounds

- When the WalkRound team arrives in the area, a brief **opening statement/introduction** should occur.



- It is also important for leadership to **elicit concerns from patients** and families during these WalkRounds.





Patient Safety Leadership Rounds

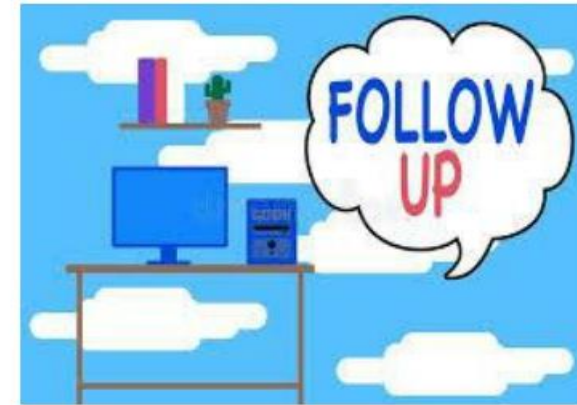
- At the end of the session, there should be a **scripted closing statement** that indicates that there will be work done to examine the **information provided**, and identify and **prioritize the improvements** to be made.





Patient Safety Leadership Rounds

- It is important that there is follow up and feedback to the staff about the issues



discussed during the

WalkRounds.



Patient Safety Leadership Rounds

- There must be a plan to provide **feedback** from the rounds to other leaders and staff of the organization.



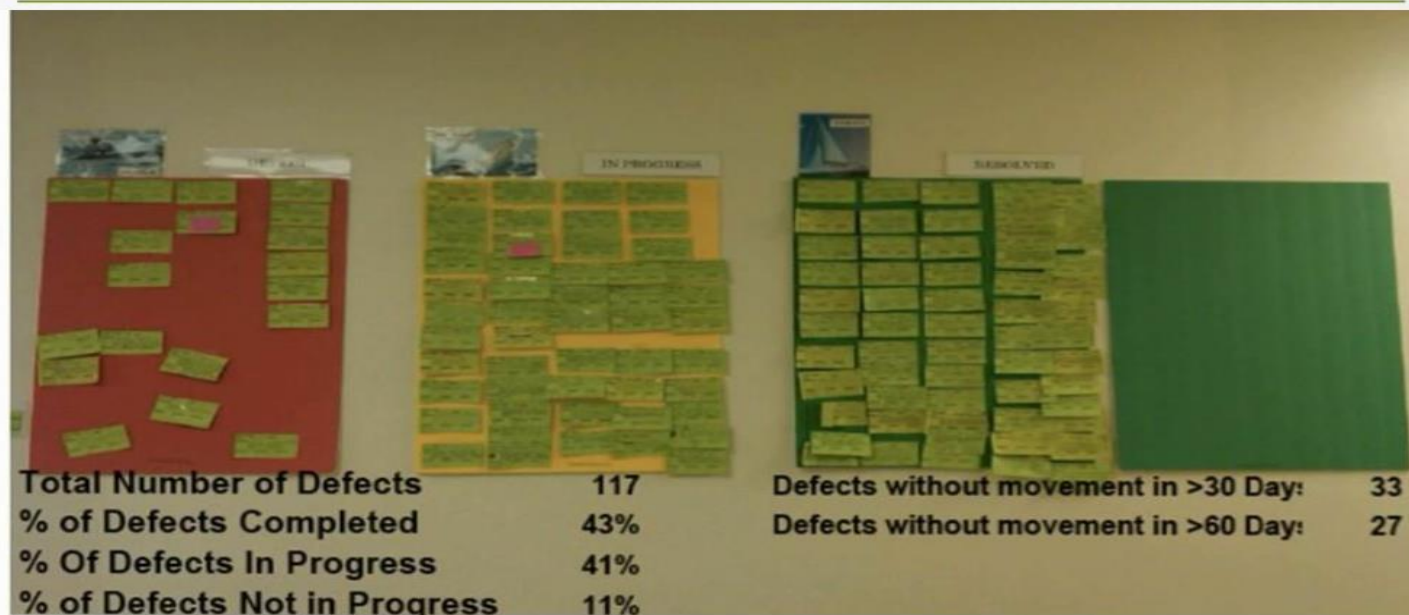
**SAFETY
MATTERS**

FEEDBACK





Learning board





What is a learning board? How can it help promote transparency?

- **Learning boards** — *digital or analog white boards* used to visually display key processes, measures, and improvement tests at the unit level — are essential in promoting operational transparency because they offer a way for people to observe the learning process in action.
- **Frontline teams** must have the expertise to *interact with the boards*, so they can understand which parts of a process are working reliably and which are not.
- The use of learning boards should be an integral part of *daily work*.
- Leaders must set expectations that managers will create learning boards to highlight and communicate about the ongoing activities and work in their areas.
- organizations must **train managers** on *how to create, use, and respond to the boards*.
- Senior leaders need to routinely visit work settings to discuss the learning system components of the framework at the learning boards.
- **During these visits**, *frontline providers and managers have the opportunity to describe the learning board*.

SPiA

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Leadership round

- **Increase awareness** of safety issues .
- Engage **senior leader with frontline staff**.
- Provide opportunity for leadership to openly discuss operational failures, safety and harm from frontline staff
- Educate staff about concept like : just culture
- Obtain information from staff about **barriers to safety**
- Assure the information collected affected actions
- **Elicit** information and **aggregate** in a useful manner

Objectives (Benefits) of Patient Safety Leadership WalkRounds

- Show their **support** for reporting of errors.
- Demonstrate **commitment** to safety.
- Communication about patient safety; leaders **talk to staff** and encourage reporting of errors.





Objectives (Benefits) of Patient Safety Leadership WalkRounds

- Engage senior leadership with frontline staff about patient safety issues.



- Increase awareness, Fuel culture for change.



Objectives of Patient Safety Leadership WalkRounds

- Openly discuss operational failures, barriers to safety, safety and harm with front line staff.
- Identify opportunities to improve safety.
- Educate staff, senior executives about patient safety concepts such as Just Culture.



Objectives (Benefits) of Patient Safety

Leadership WalkRounds

- Allows for resource allocation; the rapid

testing of safety

improvements.

- Utilize the Learning

Board.



Human factors engineering

- Methods for Improving Patient Safety.
- Interactive systems that involve people, tools and technology, and work environments.
- The top three factors that contributed to the errors were cognitive factors. Communication failures ranked fourth.





HUMAN FACTOR / ERGONOMICS

Study of the ***interrelationship*** between humans , the tools , and equipment they use in the workplace , and the environment in which they work .





- *in healthcare , 85 % of errors are the result of systems issues and 15 % are attributable to human factors.*
- *according to IHI , the key to reliable , safe care does not lie in exhorting individuals to be more careful and try harder .*

examples of human factors found to contribute to errors include the following :

- *human interaction with machines*
- *workload leading to errors and mistakes in providing the best care for patient , when there are not enough staff to handle the work load or work hours are inadequate*
- *disruptive behavior of healthcare personnel that undermines a culture of patient safety*
- *fatigue and stress leading to less than expected performance*



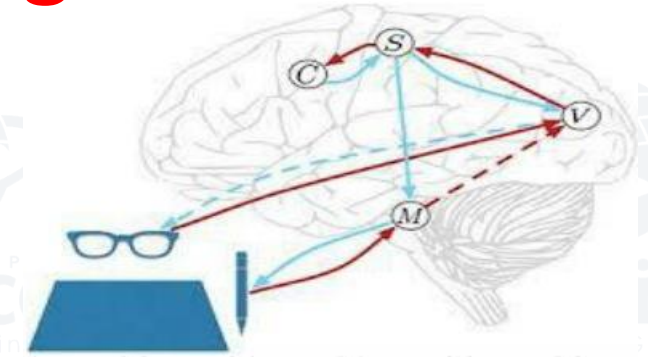
Human factors engineering

- Since individual human factors are substantial to preventing errors, there must be focus on individuals, in addition to focus on the system.
- Cognitive factors and communication failures are therefore the highest priority areas of focus when working to mitigate these types of errors.



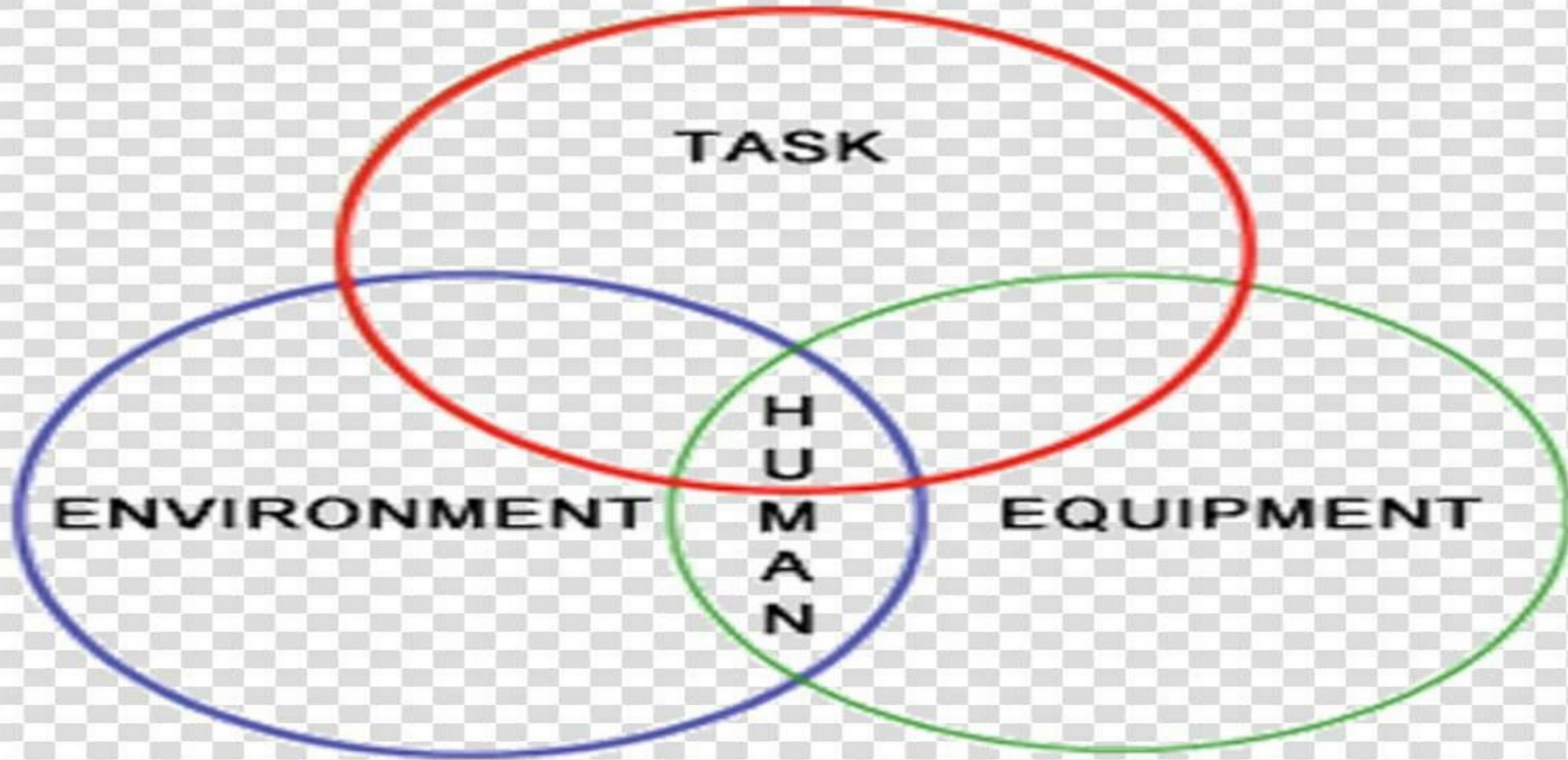
Human factors engineering

- Identify and address human issues; focus on mitigating the cognitive and perceptual errors, taking into account human strengths and limitations in the system design to ensure safety, effectiveness, and ease of use.





What is "Ergonomics"?



Human Factors

What is "Ergonomics"?

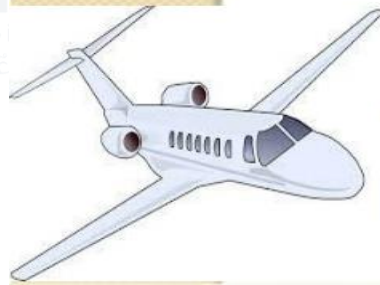


ERGONOMICS - DEFINITION

{ Human Factors Engineering (HFE) }

The study of the interrelationship between humans, the tools, and equipment they use in the workplace, and the environment in which they work.

- **"DESIGNING THE JOB TO FIT THE WORKER , NOT FORCING THE WORKER TO FIT THE JOB"**
- **SCIENCE THAT DEALS WITH DESIGNING AND ARRANGING THINGS SO THAT PEOPLE CAN USE THEM EASILY AND SAFELY**



The aviation industry was one of the first industries to incorporate human factors it into their analyses of never events.





Human and Fatigue :

Fatigue can impact an individual's performance and personality

- Reduce decision-making ability
- Prolong response time
- Increase lapses in attention
- Negatively affect short-term memory
- Lessen ability to multitask
- Increase irritability, moodiness, and depression
- Decrease ability to communicate



the science applied to healthcare fosters these principles in designed work processes :

- ***simplify*** to take steps out of a process .
- ***standardize*** to remove variation and promote predictability and consistency
- use ***forcing functions*** and constraints that makes it impossible to do a task incorrectly and creates a hard stop that can not to passed unless actions are changed .check , restrict , or compel to avoid or perform some action.
- use ***redundancies*** such as ***double check*** someone work .
- ***avoid reliance on memory*** by using tools such as ***checklist***
- promote effective team functioning (***e.g., teamwork and communication***)
- ***automate and use technology*** carefully .

Principles of human factors engineering

- Simplify.
- Usability testing.
- Standardize.
- Use forcing actions and constraints.
- Use redundancies.



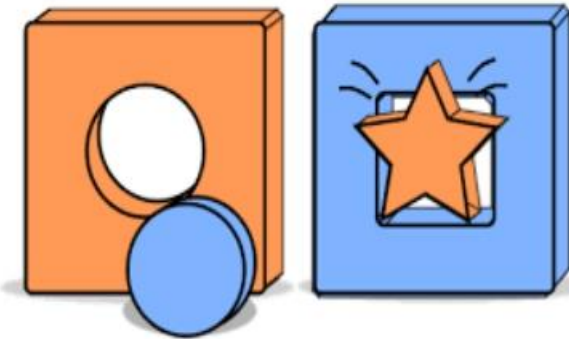
Principles of human factors engineering

- Avoid reliance on memory.
- Encourage teamwork.
- Automate carefully.
- Use visual controls.
- Mistake proofing.



Mistake proofing

- Mistake proofing, or its Japanese equivalent poka-yoke, is the use of any automatic device or method that either makes it impossible for an error to occur or makes the error immediately obvious once it has occurred.



Mistake proofing

Examples:

1. The elevator will not move if out of load.
2. Packaging medicines in plastic bags containing a single dose, or "unit dose," stops drug overuse.
3. Lock won't operate when the car doors are open.

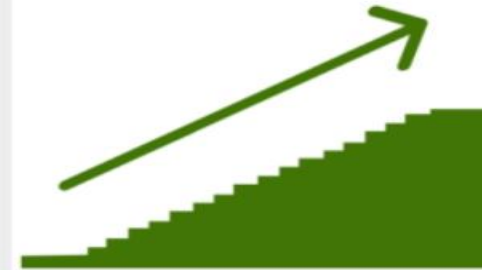


Benefits of Poka Yoke



Reduced training time

Improved safety



Promoting culture of continuous improvement

Reduced waste

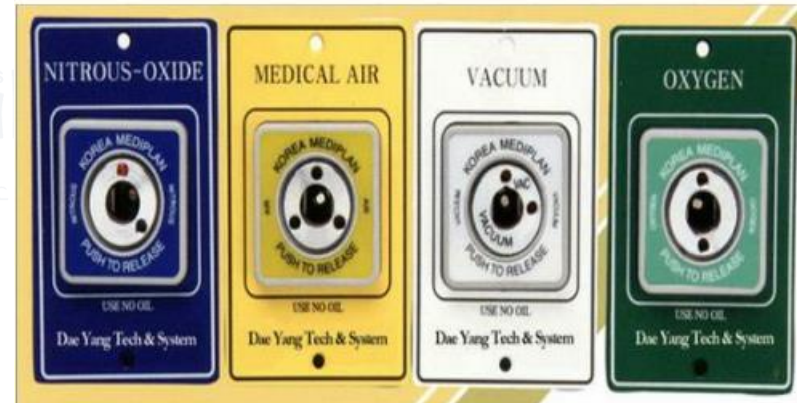


Higher productivity

Mistake proofing

Examples of Mistake-Proofing in Health Care:

- Infant Abduction Prevention.
- Bar Coding.
- Computer-Aided Nutrition and Mixing
- Private Files.
- Computer Drug Interaction Checker.
- Computerized Physician Order Entry.

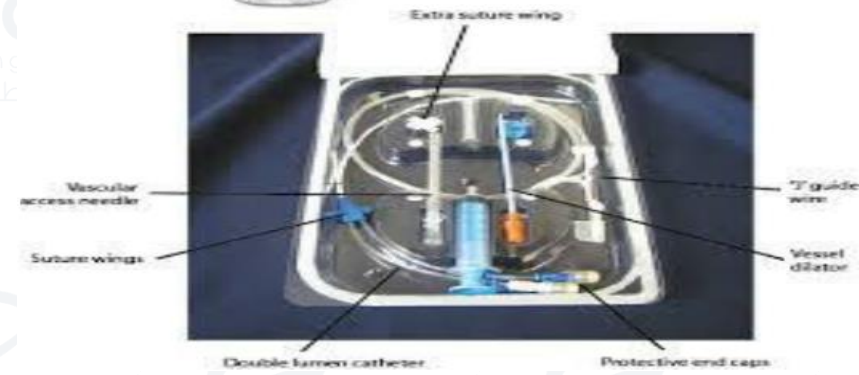


Mistake proofing

Examples of Mistake-Proofing in

Health Care:

- Plug Protection.
- Unit Dosing.
- Kits.
- Auto Shut-Off Treadmills.
- Needleless Systems.
- Distinct Labeling.



RED
RULES

Know and Comply with Red Rules

What Is A *Red Rule*?

An act having the highest level of risk or consequence to patient or employee safety if not performed exactly, each and every time



“Red” designates the rule as a **safety absolute** with the highest priority for ***exact compliance***

RULES

Red Rules Examples

- "No hospitalized patient can undergo a test of any kind, receive a medication or blood product, or undergo a procedure if they are not wearing an identification bracelet."



Red Rules Absolute Compliance

1. Patient Identification
2. Time Out
3. Two Provider Check

Time
Out

- Time Out.

Red rules

- cannot be broken
- few in number
- easy to remember
- associated only with processes that can cause serious harm to employees, customers, or the product line.
- must be followed exactly as specified except in rare or urgent situations.
- Every worker, regardless of rank or experience in the company, is expected to stop the work or production line if the red rule is violated.



RULES



RULES

Sentinel Event Process

- Sentinel event policy.
- RCA.
- The top four root causes were human factors, leadership, communication, assessment, and
- Action.
- Apology & Disclosure.



Apology and disclosure

- When adverse event occur , the patient deserve to know that and details about it .

- Organization must have formal process for disclosing information and to patient , family and how responsible for ps in organization

- Organization should determine person responsible for disclosure



According to national quality forum and its report “ safe practices for better health care “ decided that :

→ Communication with patient should be **timely** or **within 24 hr** from event

→ Should include : **what happened , empathetic communication , expression of regret , ways to prevent recurrence of error .**

→ Individual involved in this event either directly or indirectly should be **treated with respect and dignity .**

→ Staff involved should be **innocent of intentional harm** until proven otherwise

→ Staff involved in error **should be part of RCA** or other investigation .

Apology & Disclosure

- When an adverse or sentinel event occurs, All healthcare organizations **must have a formal process for apology and disclosing** this information to the patient and as appropriate to family members, and to those responsible for patient safety within the organization.

**Im
so so so!
sorry**

DISCLOSURE



Apology & Disclosure

- Support systems to assist the patient and providers with this process must be in place.
- Communication with the patient should be timely, within 24 hours of the event if possible.





Apology & Disclosure

- Communication should include the **facts** about what happened, **empathic** communication of those facts and **expression of regret** **مدن**, a commitment to investigate and, as possible, to **prevent future occurrences** of the event, and that **emotional support of the patient and family** will be provided.

SORRY
Really
sorry





Apology & Disclosure

- Caregivers are often called the "second victim" of the event.
- There may be **multiple individuals** who directly and indirectly contributed to the adverse event occurrence, due to system failures or human error.

Victim Support



Apology & Disclosure

- The individuals involved in the event either directly or indirectly should be treated with respect and dignity. **تمارك**
- Those involved in the error receive the care they need and to determine if they are "fit to work" for the protection of them and others.

SUPPORT





Apology & Disclosure

- The exception would be if they were found to be under the influence of drugs, or alcohol, or if their behavior indicated that they may have intentionally contributed to the error.

RECKLESS





Disclosure of medical error- Definition

- “Communication of a health care provider and a patient, family members, or the patient’s proxy that acknowledges the occurrence of an error, discusses what happened, and describes the link between the error and outcomes in a manner that is meaningful to the patient.” Fein et al.: Journal of General Internal Medicine, March, 2007: 755-766
- Disclosure of medical error is not a single conversation; rather, it needs to occur over time, in a series of conversations. Straumanis, 2007





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Role of Technology in Improving PS

- Computerized Physician Order Entry (CPOE).

Computerized Provider Order Entry System (CPOE)



Rev: 05/10/14

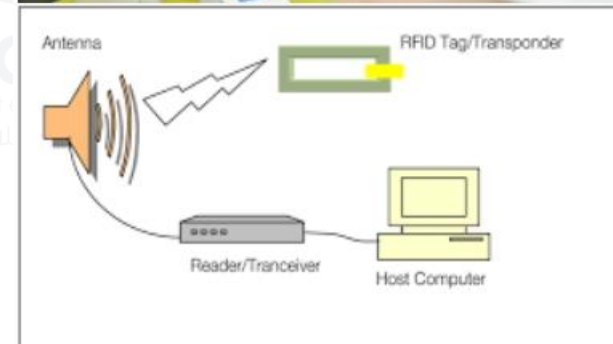
- Bar-code Medication Administration (BCMA).



- Radio Frequency Identification (RFID).

Security

- Abduction/Elopement Systems.





Meaningful use of EHR

the HITECH Act (Health Information Technology for Economic and Clinical

Health Act)

required providers to show “**meaningful use**” of an EHR system.

Meaningful use is defined as using certified EHR technology to

- **improve quality, safety, and efficiency; reduce health disparities;**
- **engage patients and family;**
- **improve care coordination, and population and public health; and**
- **maintain privacy and security of patient health information.**

- **Meaningful use compliance results include better clinical outcomes, improved population health outcomes, increased transparency and efficiency, empowered consumers, and more robust research data on health systems.**
- **Meaningful use sets specific objectives that eligible professionals and hospitals must achieve to qualify for the financial incentive programs.**



Meaningful use of EHR

When they were introduced, the Medicare and Medicaid EHR Incentive Programs were designed to measure the meaningful use of CEHRT in three stages:

Stage 1 focused on promoting the adoption of certified EHR technologies. This initial stage established requirements for the electronic capture of clinical data and giving patients access to electronic copies of their own health information.

Stage 2 expanded upon stage 1 criteria by encouraging the meaningful use of CEHRT. This stage emphasized care coordination and **the exchange of patient information**. It increased the thresholds of criteria compliance and introduced more clinical decision support, care coordination requirements and **patient engagement** rules.

Stage 3 focused on using CEHRT to improve health outcomes by implementing **protected health information**, **e-prescribing**, clinical decision support, **computerized provider order entry**, patient provider access, coordinated care through patient engagement, **health information exchange**, clinical data registry and case reporting.



Technology and Its Effects on Patient Safety

1. Computerized physician order entry (CPOE) system

- the clinician enter directly an order into the CPOE
 - electronically transmitted directly to the pharmacy or other department
 - interface with clinical decision support systems (CDSSs), which include suggestions or default values for **drug doses, routes, and frequencies, check for drug allergies, drug interactions, drug-laboratory values, drug guidelines, or prompt for corollary lab tests.**
- CPOE has been shown to be quite effective in reducing error related to the prescribing of the medication
- it has not been effective in errors occurring at the dispensing and administration stages of the medication process.





2. Bar Code Medication Administration (BCMA) Systems

- item-specific identification
- work-around
- The barcoding system has been utilized to **assure that the medication is administered** correctly with the five rights of medication administration.
- The barcode is applied to each unit dose and scanned by nurses at the bedside to connect the right medication with the right patient.

BCMA Benefits :

1-Accuracy in confirming the "five rights" of medication administration: right patient, medication, time, dosage, and route

2-integration with an electronic medication administration record (eMAR), pharmacy system, and the organization's information system

2-Comprehensive data for performance measurement and improvement

Leapfrog, an organization of payers and others that look at Patient Safety and rate hospitals on specific indicators developed in collaboration with hospital leaders and vendors, recently published a Leapfrog standard with which they will measure hospitals (Leapfrog, 2016). The four components of this measurement will include: 1. "Measurement of the extent of a hospital's BCMA implementation throughout the hospital with a focus on medical and/or surgical units (adult and pediatric) and intensive care units (adult, pediatric, and neonatal)"; 2. "A hospital's compliance with both patient and medication scans at the bedside prior to administering medications"; 3. "The types of decision support that the hospital's BCMA system offers"; and 4. "A hospital's structures to monitor and reduce workarounds" (Leapfrog, 2016).

3. Radio Frequency Identification (RFID)

- **automatic identification system**, using digital memory chips embedded on tags to **track** medical devices, drugs, staff, patient, and so on.
- **contain information** about the **lot number** and **expiration date** for medical supplies and drugs or **allergies** and **blood type** for patients, or the **physical location** of equipment and patients in real time.
- **Data can be read by sensors from a distance** and can be transmitted to a host computer for processing and tracking, it has both read and write capability
- **RFID is utilized for three purposes:**
 1. **asset management (equipment location)**
 2. **patient care (patient tracing, helpful in infant abduction)**
 3. **inventory management (maintenance log)**

A disadvantage of RFID is the expense of the equipment, both hardware and software



Abduction/Elopement Security Systems

- **RFID** technology is used increasingly for infant and pediatric security to **prevent abduction**
- bracelet that is placed around the infant or child's wrist or ankle. If the bracelet is removed or cut off, an alarm signals the nursing station and computer software, alerting the healthcare staff.
- Usually the facility incorporates door and elevator locks, and goes into "lockdown mode"
- **a mother/infant matching system**, where the mother is given a tag or band with the same code as her infant's, to serve as an additional and automatic identification
- **adults with dementia**





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THANK YOU

Obrigado, Chon, Mamana, Kiin, Merci, Raibh Maith Agat, Asa, Mul, Tia, Ora, Grazie, Ci, do, k Je, s, hachakkeram, Kiitos, Spasibo, Niringrazzjak, Matur Nuwun, Chokrane, Raibh Maith Agat, Maake, Kiitos, erma Kasih, Arigat-

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