Preventing for Survey Readiness

Tips and Tools for a Successful Accreditation Survey

February 7, 2014

Patient Safety

*Putting Patients First And Keeping Patients Safe* is a UH initiative that demonstrates our commitment to exhibiting the strategies of a High Reliability Organization (HRO).

**What is a High Reliability Organization?**

Every member of the hospital and medical staff should be familiar with the term and its meaning, so here are the five key characteristics of an HRO:

- **Sensitivity to Operations**
  Focus on systems and processes and how they affect patient care.

- **Reluctance to Simplify**
  Systems are made simple, but the explanation for failure is rigorously pursued and understood.

- **Preoccupation with Failure**
  Relentless pursuit of perfection and a constant search for what might go wrong.

- **Deference to Expertise**
  Information is freely shared and staff are engaged.
  In a crisis, the person with the most expertise leads.

- **Resilience**
  The organization quickly contains and mitigates errors.

We should not only know what an HRO is but use the term in our conversation about our patient safety initiative.

The Joint Commission has made its position clear: **Reducing errors which threaten patient safety is one of its highest priorities.** And it has charged health care leaders to devise programs to combat errors that jeopardize the well-being of patients.

**Patient safety** is an integral element of University Hospital’s mission and quality initiatives. It is also the commitment we have made to deliver the most compassionate and effective care possible to our patients.

### The Joint Commission’s Standards on Safety

*The Joint Commission has created the following standards to address the issue of medical errors.*

1. Ensure that appropriate mechanisms exist to report, intervene, and follow up on events and near-misses.

2. Design a central, coordinating patient safety committee that interfaces with other related activities.

3. Create a proactive risk-reduction process.

4. Establish a process for patient and family communication about occurrences.

5. Outline a comprehensive education and communication plan to include the Board, leadership, faculty, and staff of University Hospital.

6. Develop a non-punitive reporting culture.

7. Identify monitoring activities and outcomes, and report to leadership at least quarterly.

**Test Your Knowledge**

*Here’s a question from last week’s issue. Do you know the answer?*

**Q.** What number do you call in the event of a chemo drug, blood or other infection disease spill?

**A.** 2-1500
Our Focus

University Hospital faces three significant challenges as we continue with our patient safety plan:

- Reduce medical errors by improving the systems and processes of delivery care.
- Continue the development of a “Just Culture”: a non-punitive reporting atmosphere promoting full and open disclosure of occurrences.
- Continue to execute strategies of a High Reliability Organization.

Questions and Answers

Q: What makes the patient safety initiatives different from our quality and performance improvement activities?
A: University Hospital's patient safety program has always been a critical part of our mission and closely linked with all of our quality and performance improvement activities. It is also mandated by New Jersey law. Patient safety initiatives focus on proactive measures to prevent errors by identifying potential risks.

Q: How do we ensure the safety of our patients and employees?
A: By continually focusing on improving processes and conditions identified as dangerous or potentially dangerous by staff or patients and/or through the analysis of incidents, data, and trends.

Q: What are some of the areas in which we are addressing patient safety?
A: We monitor processes such as those reported via Patient Safety Net (PSN), analyze the results, and then look at opportunities for improvement using our PDSA (Plan – Do – Study – Act) model.

- We review and distribute Joint Commission Sentinel Event Alerts and implement the appropriate recommendations.
- We conduct routine patient safety surveillance rounds and life safety inspections.
- We implement processes and monitor compliance to the National Patient Safety Goals.

Q: What methods are employed to address patient safety concerns or events that have occurred?
A: Failure Mode Effects Analysis (FMEA) is a proactive safety analysis technique that systematically examines vulnerable areas or processes in order to determine potential failures and what their effects would be.

Root Cause Analysis (RCA) is a retroactive analysis patient safety technique which examines events that have already occurred to determine the “root causes” and develop action plans to affect future performance.

Q: How can staff participate in the patient safety effort?
A: Staff is encouraged to identify areas of risk even before problems occur and take measures to reduce the risk. Staff is also given access to PSN to report events or near-misses as they occur. As a part of orientation, we train staff about their responsibilities for patient safety. Call 2-7373 for the patient safety office or PSN training.

Q: How can patients participate in the patient safety plan?
A: During the admissions process, we encourage patients to be involved in their own health care and notify staff of any potential safety risks that concern them. Recognizing the central role patients and their families play in this process, we have implemented the National Patient Safety Foundation Ask Me 3 initiative. This program encourages patients to ask their health care providers three questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Q: Are patients informed about the outcome of treatment? Who tells them?
A: Yes, the appropriate physician or staff member will communicate clinical outcomes to the patient and family and follow the policy: Patient Safety - Informing Patients About Unanticipated Outcomes - Policy No. 831-200-196 (for example, informing a patient when there is an unexpected adverse outcome).

Q: What is an unexpected adverse outcome?
A: A result from a treatment or procedure that differs significantly from what was anticipated. Note: An unanticipated outcome may be negative or positive and may or may not be associated with an error. (American Society for Healthcare Risk Management)

Each of us should be prepared to talk about our role in patient safety and what we’re doing to reduce risks in our areas. It’s up to us!