Hospital Challenges When Striving Towards Safer Health Care

The 1990s were a decade of changing ideas regarding the nature of patient risk. Earlier mental models had the often unstated assumption that well-trained intelligent practitioners can provide sufficiently reliable care. However, we began to realize that humans, in a field as complex and dangerous as health care, could not do so. The publication of "To Err is Human" capped off this decade, and brought this issue of patient safety and human reliability to the forefront.

Nevertheless, since then progress has been difficult. There are many reasons why becoming highly reliable "six-sigma" organizations is difficult, some of them having to do with the very nature of health care. This article will start looking at some of the challenges. Identifying the challenges helps us surmount them.

I divided the problems into six large categories: culture, designed environment, resources, customization, complexity and change — others may see this differently, and I encourage your contribution to the newsletter. In this month's article, I'll briefly give an example of each. Future articles will go into more detail and discuss some of the ways we can work together to address these issues.

Culture: The traditional near-exclusive expectation is that individual action and individual responsibility is the best way to deliver care (it still is important, but we need to combine it with teamwork and systems that protect patients, when appropriate).

Designed Environment: Processes, equipment and facilities often do not take into account human performance factors.

Resources: Change will take personnel time, money and human performance/process design expertise — each of which is scarce in hospitals.

Customization: Successfully delivering care to each patient requires that all relevant information (e.g., patient status, treatment evidence base, facility and personnel capabilities) is considered, even when we seek to standardize care.

Complexity: The delivery system has many actors and entities that may have only a loose connection with each other — e.g., doctors, hospitals, long-term care facilities.

Change: Changing the way we deliver care brings in new risks as it reduces the old — The Joint Commission's sentinel event alert "Safely implementing health information and converging technologies" details one such example.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

CHPSO to Hold Free Web Seminars on Services

CHPSO and its data partner, Quantros, will hold two complimentary web seminars to introduce hospitals to CHPSO information services.

The first web seminar — Dec. 1 from 11 AM to noon — will discuss the CHPSO web interface. Member hospitals will have free access to a number of valuable services and information, including simple point-and-click submission of incident reports to CHPSO; hospital-specific analysis of submitted incident reports, with benchmarking; peer collaboration through secure access to web communication and social networking portals; and a patient-safety resource library, including topical content for general items, event-specific resources, regulatory changes and alerts.

The second web seminar — Dec. 16 from 1 PM to 2 PM — will help information technology departments understand the XML format for data transmission to CHPSO, and facilitate the production of automated processes to prepare incident reports for potential submission. Using the automated submission process, personnel time required to submit incident reports will be minimal

To register, contact La Shon Tate at ltate@calhospital.org or 916.552.7616). For more information, contact Rory Jaffe at 916.552.7568 or rjaffe@calhospital.org.

Name That Drug
(answer on last page)

Disp: hydralazine 25mg
Sig: #100 1-2 po 8° prn itch

Resolving the I/We Dichotomy

You may recall from last month that the five steps necessary for success in "democratizing innovation" are resolving the I/we dichotomy, servant leadership, team skills, hardwired innovation and accountability.

The first step is quite simple for some, but a real challenge for others. I've heard clinicians who refuse to countenance the notion that one can, and should, behave as a team member in a clinical context. Usually, the reason is they feel personal responsibility and accountability will be lost or at least diluted by a team paradigm. I can certainly understand their concern in this regard, but if it's done properly there is actually enhanced accountability within the team context. I'll discuss that at greater length next month. There are others who may react negatively because they invested a lot of money and many years gaining their expertise and title. They don't feel like they should lose the respect their position deserves. I can empathize with this line of thinking, and in fact I had the same concerns when we began to implement teamwork and communication training in aviation. What I've found is that my authority hasn't been diminished at all, and I get the respect that I pay to others.

This demonstration of respect is a good example of the second tenet: servant leadership. Many of us gained our first impressions of leadership from the movies and TV. Unfortunately, those leadership styles tended to be very stereotypical — the harsh, demanding, mean SOB that everyone adores because he gets such great results. In a nutshell, when you're leading clinicians, that simply won't work. Servant leadership means you work *for* your subordinates. You remove obstacles that make their work more difficult; you

look for opportunities to help them; and you thank them for their work. Again, it's a little scary to abandon the throne, but I've found that I don't need to remind people that I'm in charge, and they work harder for someone that treats them with dignity and respect.

— Steven Montague lifewings@verizon.net, Vice President, LifeWings

Southern California Patient Safety Colloquium Set for Jan. 28

The second annual Southern California Patient Safety Colloquium will be held on Jan. 28, 2010. The early-bird registration fee is available until Jan. 8. The entire agenda with 18 breakout sessions is now finalized. Keynote speakers will include:

- Ron Galloway — producer of the documentary "Rebooting Healthcare"; will discuss how quality and safety fit.

- John Nance, JD — author of "Why Hospitals Should Fly"; will address what it will take for health care to be as safe as it truly can be.

- Charles Denham, MD — Chairman of TMIT and leading the NQF Safe Practices research; will present "Add Patients, Change Everything."

Date: January 28, 2010; **Location**: Hilton Pasadena, 168 South Los Robles Avenue, Pasadena, CA 91101; **Check In/Breakfast**: 7:00 AM; **Program**: 8:15 AM - 5:00 PM.; **Cost**: $99 early-bird registration fee until Jan. 8, 2010 — $125 per person after Jan. 8, 2010.

To view the entire agenda and the breakout session topics, please see the updated SCPSC Event Brochure. Click here for event summary and to register online. Mail in registrations may be done by using the SCPSC Registration Form.

Information Resource for Patient Safety

CHPSO is establishing a central information resource to assist hospitals in their patient safety and quality improvement initiatives, and allow hospitals to contribute and share implementation examples. These resources will be posted on the CHPSO web site (www.chpso.org). Specific topics currently on-line are: catheter-associated urinary tract infections, central line-associated blood stream infections, *C. difficile* infections, deep venous thrombosis and pulmonary embolism, hand hygiene, medication safety, multi-drug resistant organisms, sepsis, surgical safety, and ventilator-associated pneumonia. Topics will continue to be added, and the current topics will be updated and augmented regularly.

Implementation can be assisted through sharing of "implementation examples" that will help share the lessons learned and reduce resource expenditure through more efficient implementation in subsequent locations. CHPSO will share this information to the benefit of all. The following form (see next page) is designed to help you put together a very brief report that can be shared. If any of the questions are not applicable, leave them blank. A copy of the form is available at www.chpso.org/impexes.doc. Send implementation examples to info@chpso.org.

Topic/Area: (focus for work)	Submitted by: (contact name and email address)	Health Care Setting: (site name)
What was your **Aim or Goal** for your improvement work?	**What specifically did you test**? (list out if more than one test of change)	What were the **outcome(s)** of your test(s) of change worth sharing?
Were there any **key lessons learned** that you acted upon?	Any **useful tools** you have adopted that worked and were adopted for spread? (e.g., forms, guidelines, processes, education — if so, please attach samples)	Any **other key components to success** you would like to share?

Calendar

Following is a list of upcoming events that are still open for enrollment. For more information or to enroll, use the contacts listed below.

December

1: *CHPSO*: Introduction to CHPSO Web Interface and Information Services. Web seminar, 11 AM – noon.

2: *BEACON* (The Bay Area Patient Safety Collaborative): PSQI, Practical Skills for Quality Improvement. San Francisco.

4: *CAPSAC*: California Patient Safety Action Coalition Meeting Los Angeles.

15: (Date change — originally December 3) *SCPSC* (Southern California Patient Safety Collaborative): Clostridium difficile-Associated Diseases, High Alert Medications, Hospital Acquired Pressure Ulcers and Medication Safety. Los Angeles.

16: *CHPSO*: Transmitting data to CHPSO: XML format, data transmission protocols, and process automation. Web seminar, 1 PM – 2 PM.

January 2010

13: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

14: *BEACON*: Compass Series course day 1 (of 4). Location to be determined.

26: *BEACON*: Quarterly Meeting. South San Francisco.

28: *HASC* (Hospital Association of Southern California): Southern California Patient Safety Colloquium. Pasadena.

February 2010

10: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

11: *HASD&IC* (Hospital Association of San Diego & Imperial Counties): San Diego Patient Safety Council. San Diego.

11: *BEACON*: Compass Series course day 2 (of 4). Location to be determined.

18: *BEACON*: Key Contacts Meeting. Location to be determined.

March 2010

4: *BEACON*: Physician Leadership Meeting. Location to be determined.

5: *BEACON*: CNE Meeting. Location to be determined.

10: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

11: *BEACON*: Compass Series course day 3 (of 4). Location to be determined.

12: *CAPSAC*: California Patient Safety Action Coalition Meeting. Sacramento.

April 2010

7: *HASD&IC*: San Diego Patient Safety Council. San Diego.

14: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

15: *BEACON*: Compass Series course day 3 (of 4). Location to be determined.

27: *BEACON*: Annual Meeting. Santa Clara.

May 2010

12: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

13: *BEACON*: Compass Series course day 1 (of 4). Location to be determined.

13: *BEACON*: Leadership Council. Location to be determined.

June 2010

2: *HASD&IC*: San Diego Patient Safety Council. San Diego.

9: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

10: *BEACON*: Compass Series course day 2 (of 4). Location to be determined.

11: *CAPSAC*: California Patient Safety Action Coalition Meeting Location to be determined.

July 2010

8: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

9: *BEACON*: Compass Series course day 3 (of 4). Location to be determined.

27: *BEACON*: Quarterly Meeting. Location to be determined.

August 2010

11: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

12: *HASD&IC*: San Diego Patient Safety Council. San Diego.

12: *BEACON*: Compass Series course day 4 (of 4). Location to be determined.

September 2010

8: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

9: *BEACON*: Compass Series course day 1 (of 4). Location to be determined.

10: *CAPSAC*: California Patient Safety Action Coalition Meeting Location to be determined.

10: *BEACON*: Key Contacts Meeting. Location to be determined.

23: *BEACON*: Physician Leadership Meeting. Location to be determined.

24: *BEACON*: CNE Meeting. Location to be determined.

October 2010

6: *HASD&IC*: San Diego Patient Safety Council. San Diego.

December 2010

1: *HASD&IC*: San Diego Patient Safety Council. San Diego.

3: *CAPSAC*: California Patient Safety Action Coalition Meeting. Location to be determined.

For further information on these events:

BEACON: Pamela Speich pspeich@hospitalcouncil.net or www.beaconcollaborative.org

CAPSAC: Theresa Manley manleyt1@pamf.org or www.capsac.org

CHPSO: Rory Jaffe info@chpso.org

HASC: Catherine Carson ccarson@hasc.org

HASD&IC: Nancy Pratt nancy.pratt@sharp.com

Name That Drug
(answer)

The prescription was intended to be for **hydroxyzine** From the ISMP error analysis:

"Many health care professionals may wonder why doctors need to include purpose on prescriptions… The prescriber in this case confused hydralazine with hydroxyzine. Because the purpose of the prescription was included, the pharmacist immediately recognized the error and had the order changed to hydroxyzine."

— Rory Jaffe, MD MBA, rjaffe@calhospital.org

About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient-safety events and news of patient-safety activities in this state. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter will be archived on the CHPSO website (www.chpso.org). Send subscription requests (additions, deletions) to ltate@calhospital.org. Submit articles to rjaffe@calhospital.org.