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@cal-hospital.org. Submit articles to rjaffe@calhospital.org.

WHO Releases Guidelines on Hand Hygiene in Health Care

Launched May 5, 2009, the **SAVE LIVES: Clean Your Hands** initiative aims to support health-care workers to improve hand hygiene and stop the spread of infection. As part of the campaign, the World Health Organization (WHO) released an extensive hand hygiene promotion toolkit and *WHO Guidelines on Hand Hygiene in Health Care*. The 270-page publication is much more comprehensive than the title suggests. Its content includes:

Scientific Data Review
- Normal skin flora and physiology
- Transmission and acquisition of pathogens
- Review of hand hygiene preparations
- Evidence-based surgical hand preparation
- Adherence to hand hygiene: religious, cultural, and behavioral considerations

California Patient Safety Action Coalition Advocates for a 'Just Culture'

Between liability lawsuits and mandatory public reporting of medical errors, California has many ways to hold health care providers accountable for mistakes. Despite a strong system of accountability, however, rates of medical errors in the state have not decreased, say members of a new alliance of health care industry stakeholders and patient safety experts.

Members of the California Patient Safety Action Coalition (CAPSAC), formed in 2008, argue there is a better way to reduce the number of medical errors and near misses that occur each year in California. They advocate a "Just Culture" system of managing human errors that encourages finding and fixing the places where errors are most likely to happen by reporting and tracking every mistake and near miss, even those that cause no harm.

"This sounds obvious, but it is difficult to create a system where health care providers feel comfortable speaking up when they make a mistake or catch themselves nearly making a mistake," Teresa Manley, chair of CAPSAC, says. "The Just Culture system does this by recognizing that there is a difference between a human error and reckless or careless behavior that the provider knows is likely to cause patient harm."

What Does 'Just Culture' Involve?

Recent headlines discussed the behavior of the pilots on Continental Flight 3407. The Wall Street Journal's May 13, 2009 front-page story, titled "Doomed Pilots Talked of Inexperience," highlighted behaviors addressed in the Just Culture model. The article cited an airline investigator who was "struck by how frequently Colgan pilots violated safety rules by engaging in idle chatter in the cockpit." This is a clear example of "drift" occurring within an organization, and in the same article this was described as a "systemic … part of the culture."

The challenge for health care organizations is that the same drift and risk-taking behavior is present in all of our health care settings. The nurses, physicians and pharmacists may not see the inherent risk in the behaviors, and in some instances the drift is due to the competing priorities within the environment of care. The event investigations also may not try to explain why front-line staff make a behavioral choice to violate a rule, or what the preceding cause was to a human error. Without a good event investigation, discipline may occur when it was not warranted, or at-risk behavior may be tolerated due to a lack of awareness that the entire work unit is making the same behavioral choices. This fall, CAPSAC will offer regional training on how to complete a Just Culture event investigation.

To learn more about the Just Culture approach to improving patient safety, visit www.capsac.org. Both CHPSO and the California Hospital Association (CHA) are CAPSAC members. For the full member list, visit www.capsac.org/members.html.

WHO Clean Your Hands, continued from page 1

Consensus Recommendations
Process and Outcome Measurement
- Performance indicators
- Economic impact

National approach to hand hygiene improvement
- Mass media, social marketing, social movement
- Benefits and barriers of national programs

Patient involvement in hand hygiene promotion
- Patient empowerment and its effects

The document is available on the CHPSO web site at www.chpso.org/hygiene/ along with an extensive hand hygiene campaign toolkit.

— Rory Jaffe rjaffe@calhospital.org.

Wrong Site or Side Surgery Error Analysis Form Available

The Pennsylvania Patient Safety Authority has published a form for general use in wrong site or wrong side surgery occurrences or near misses. The form asks a series of questions to help develop a structured view of the event. Hospitals are encouraged to review the form to see whether it augments their current approach to these events.

The form includes specific yes/no questions about possible contributory factors, including 16 questions about scheduling, 13 on consent, 25 on preoperative verification, 22 on time-out, and five on marking.

For a copy of the form, go to www.patientsafetyauthority.org/Educational-Tools/PatientSafetyTools/PWSS/Documents/wss_error_analysis.pdf.

— Rory Jaffe rjaffe@calhospital.org.

Just Culture: Identifying Unsafe Acts

One challenge with establishing a "Just Culture" is drawing the line between acts deserving personnel actions, such as discipline or remedial training, and acts representing normal human error, in which the culprit is the system not the person. When the culprit is the system, protecting future patients is done through improving the system, to make errors less likely to occur or less likely to adversely affect patients.

An algorithm can assist in this differentiation, although judgment is still required. One example of this algorithm is in use in the UK National Health Service. It identifies four types of culpable acts. Errors that do not include any of the culpable acts are then seen as systems problems. The four culpable acts are bad intent, impairment, recklessness, and poor judgment.

The Deliberate Harm Test (Bad Intent)

In most patient-safety incidents, the individual had the patient's well being at heart. However, in some cases the intent was to cause physical or emotional harm. The Deliberate Harm Test asks questions to help identify or eliminate this possibility at the earliest possible stage.

The Physical/Mental Health Test (Impairment)

If intent to harm has been discounted, the Physical/Mental Health Test helps to identify whether the individual's (not the patient's) ill health or substance abuse caused or contributed to the patient-safety incident.

The Foresight Test (Recklessness)

If intent to harm and incapacity have been discounted, the Foresight Test examines whether protocols and safe working practices were adhered to.

The Substitution Test (Poor Judgment)

Finally, if protocols were not in place or proved ineffective, the Substitution Test helps to assess how a peer would have been likely to deal with the situation.

For more information, including copies of the incident decision tree and a guide to its use, visit www.chpso.org/just/.

— Rory Jaffe rjaffe@calhospital.org.

2008 National Healthcare Quality Report: CAUTIs

The urinary tract is a common site of health care associated infection (HAI). Catheter use and specific comorbid conditions can increase the risk of developing a urinary tract infection (UTI). Approximately 40 percent of all HAIs are attributed to catheter associated UTIs (CAUTIs).
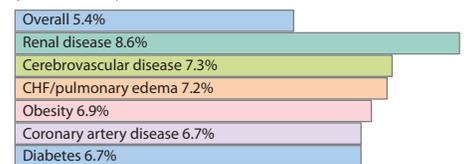

Overall 5.4%
Renal disease 8.6%
Cerebrovascular disease 7.3%
CHF/pulmonary edema 7.2%
Obesity 6.9%
Coronary artery disease 6.7%
Diabetes 6.7%

Chart: Adult surgery patients with postoperative CAUTI, overall and by selected comorbid conditions, 2006.

— full report at www.ahrq.gov/qual/nhqr08/nhqr08.pdf.

IJ Corner: WHO Surgical Safety Checklist to Reduce Errors

The California Department of Public Health (CDPH) issued 13 Immediate Jeopardy (IJ) fines on May 20. CDPH defines IJ as a situation in which the licensee's non-compliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to a patient. The non-compliance is often the result of not following hospital policy.

The IJs related to medication safety (four events) and surgical safety (three events). The IJ Corner this month will focus on surgical safety. All three events involved a patient who needed to be returned to surgery because of a retained foreign object.

The CHA Board voted recently to endorse the World Health Organization (WHO) Surgical Safety Checklist, considering that improvement of surgical safety is essential to public health. CHA also asked California hospitals to try using the WHO checklist to gain a broad understanding of the feasibility of adopting the principles of the checklist as a statewide standard.

Both CHPSO and CHA consider the improvement of surgical safety as essential to public health and endorse the concept of the "WHO Surgical Safety Checklist." Many California hospitals are using this effective tool to reduce surgical errors. Using the checklist reduces the chance of overlooking important information at three points during the patient's care: 1) at check-in; 2) at the time-out; and 3) at the end of the case.

The majority of the activities on the checklist are already implemented in most U.S. hospitals, and most already have checklists for a portion of the patient's care (particularly check-in), so this should not represent a major change in practice patterns, but would add some rigor to the critical phases, particularly at the end of the case. Certain aspects of the checklist are intended to improve team communication

The checklist was developed for worldwide use and some hospitals have altered the checklist slightly (eliminating standard care in U.S. operating rooms or adding an additional step). CHPSO encourages hospitals to review the WHO surgical checklist information at www.chpso.org/whosurg/.

— Debby Rogers, drogers@calhospital.org.

Using Checklists to Make Complex Tasks Safer: The Boeing 299 Experience

In 1935, the US Army Air Corps concluded its testing of new multi-engined bombers. The Boeing 299 was the obvious frontrunner, outperforming the others in virtually every category. The Air Corps intended to buy the 299. However, it crashed immediately after takeoff on what was to be its second evaluation flight, killing two and injuring others.

The cause was human error: in managing the complex aircraft controls, the pilot forgot disengage the control surface locks (used to protect the control surfaces when the plane was parked) prior to takeoff. Some news reports labeled the 299 as "too much plane for one man to fly" and the Air Corps decided to buy the Douglas B-18 instead.

Because of the potential superiority of the 299, 12 more 299s were made and tested at Langley Field, Virginia. The test pilots developed a way to ensure that this complex plane could be operated safely. They produced checklists and procedures to ensure that human memory was not the limiting factor in aircraft safety. After 1.8 million test miles without a serious incident, the Air Corps began using the 299 in earnest. Renamed the B-17 "Flying Fortress," 12,731 were produced and became a major component of the allied bomber forces in World War II. In contrast, only 350 B-18s were purchased by the Air Corps; none after 1938.

The checklists and procedures continued to be refined. Lessons learned then about effective use of checklists are still applicable today. The B-17 F & G Model Flying Fortress Pilot Training Manual (www.chpso.org/newsletter/images/20090602.gif) provides good advice for checklists (emphasis in the original):

> Bear this in mind: **It is absolutely essential that the cockpit checklist be used properly by pilot and copilot at all times.**
>
> The number of procedures necessary for the safe and efficient operation of the B-17 are far too many for even the most experienced pilot to carry in his head. The best trained pilots are likely to forget things occasionally. **There is no place for forgetfulness in flying the B-17!** Your cockpit checklist is the only sure safeguard against it.
>
> Proper use of the checklist requires a **definite procedure** and **active cooperation** between the pilot and copilot….
>
> The copilot, with checklist in hand, has the responsibility of seeing that no item on it is left unchecked inadvertently.

— Rory Jaffe rjaffe@calhospital.org.

Who's Responsible?

I received a thoughtful question yesterday from a perioperative clinical nurse specialist with whom I've been working. Linda asked me, "How is 'vitality' kept in the checklist? How do we keep from approaching it robotically?" There are two issues here. First is "mindfulness," meaning that we're not just "going through the motions" of completing the checklist. Second, and more fundamental in my experience, is getting all of the items actually done. I found this question really interesting because the two most recent aviation accidents involving fatalities (Lexington 2007, Buffalo 2009) both involved a lack of organizational discipline and a cavalier approach to checklist discipline.

The simple fact is that every organization, even a "high reliability organization" struggles with discipline or, more accurately, the lack of discipline. How does a manager ensure her people are actually doing the things they're supposed to do? If the organizational construct relies strictly on the manager for ensuring compliance, it's facing an uphill battle. Managers and physician leaders simply can't be in every OR, at every bedside, in every ED consult, to ensure that clinicians are "doing the do's." I think there is ample evidence in healthcare that there is a better way to ensure compliance.

While leadership actions are necessary, they're not sufficient. There are three best practices that are also powerful means of improving compliance with checklist expectations. The first of these is voluntary compliance because the procedure, protocol, checklist, or behavior is widely understood to be a best practice of the true professional. This is exactly the approach that Dr. Peter Pronovost took to implement the Vascular Access Checklist at Johns Hopkins, and that the World Health Organization is taking to implement the Surgical Safety Checklist. They've taken known clinical best practices and then built them into the standardized tool (checklist). These best practices don't have to be proven techniques published in peer-reviewed literature. They can be practices that simply have obvious face validity or best practices driven by metrics captured locally (as Pronovost did).

Next month, I'll share the other two best practices I've learned from health care organizations that are successfully incorporating high reliability techniques, and then in the following months we'll address "mindfulness."

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

Leaders' Influence on Organizational Culture

Culture is deep seated and difficult to change, but leaders can influence or manage an organization's culture. It isn't easy, and it cannot be done rapidly, but leaders can have an effect on culture…. some specific steps leaders can employ:

- **What leaders pay attention to, measure and control**. Something as simple as what is emphasized or measured, over time, can have an effect on an organization's culture…

- **Leader reactions to critical incidents and organizational crises**. The way leaders react to crises says a lot about the organization's values, norms and culture. Crises, by their nature, bring out the organization's underlying core values…. Disconnects between actions and words will usually be apparent, and actions always speak louder than words….

- **Deliberate role modeling, teaching, and coaching**. Nothing can take the place of leaders "walking their talk." The personal example of a strategic leader can send a powerful message to the members of an organization, particularly if it is ethical and consistent. Reinforcing that example with teaching and coaching will help others to internalize the desired values.

- **Criteria for allocation of rewards and status**. The consequences of behavior—what behavior is rewarded and what is punished—can significantly influence culture. If the organization reacts to new ideas by ridiculing the ideas and those who propose them, it won't take long before people believe that new ideas are not welcomed or desired….

- **Criteria for recruitment, selection, promotion, retirement and excommunication**. One of the powerful ways of changing an organization's culture is through the type of people brought into, retained, and advanced in the organization. You should be able to establish a desired culture base in an organization by bringing in and advancing individuals with the values you want, and eliminating those with undesired value bases.

— National Defense University, from tinyurl.com/al5gq.

Calendar

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

June

2: *Board of Pharmacy*: Subcommittee to Evaluate Drug Distribution with Hospitals. San Francisco.

Calendar, continued from page 4

2: *Hospital Council* (Hospital Council of Northern & Central California): Developing, Measuring and Documenting Employee Competence (audience: HR and ancillary support staff). Oakland.

3: *Hospital Council*: Developing, Measuring and Documenting Employee Competence (audience: Nurse Leaders). Oakland.

16: *HASC* (Hospital Association of Southern California): Clostridium difficile-Associated Diseases, High Alert Medications, Hospital Acquired Pressure Ulcers and Medication Safety. Industry Hills.

July

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

August

4: *HASC*: Central Line Blood Stream Infection, MRSA, Sepsis Mortality, and Surgical Care Improvement Project. Industry Hills.

September

2: *HASC*: Clostridium difficile-Associated Diseases, High Alert Medications, Hospital Acquired Pressure Ulcers and Medication Safety. Industry Hills.

11: *CAPSAC*: California Patient Safety Action Coalition Meeting. Napa.

November

3: *HASC*: Central Line Blood Stream Infection, MRSA, Sepsis Mortality, and Surgical Care Improvement Project. Industry Hills.

December

3: *HASC*: Clostridium difficile-Associated Diseases, High Alert Medications, Hospital Acquired Pressure Ulcers and Medication Safety. Industry Hills.

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

For further information on these events:

Board of Pharmacy: www.pharmacy.ca.gov/about/meetings.shtml#distribution

CAPSAC: Theresa Manley, manleyt1@pamf.org

HASC: Catherine Carson, ccarson@hasc.org

Hospital Council: Cheree Muñoz, cmunoz@hospitalcouncil.net

CHPSO will:

• Offer health care providers a secure environment—protected by legal privilege and confidentiality—to conduct patient safety activities so that health care providers can analyze quality and safety issues to improve care and reduce risk to patients.

• Encourage health care providers to voluntarily submit and share information, which will be de-identified and used to track patient safety trends nationwide.

• Give feedback to health care providers on ways to reduce risk and improve patient quality and safety.

• Publicize the achievements of member hospitals and the regional collaboratives.

Frequently Asked Questions About Working With CHPSO

Why do we need to sign a contract? The contract outlines the responsibilities of both CHPSO and providers to protect the confidentiality of the shared data. Also, CHPSO is a business associate, so a HIPAA business associate agreement is needed.

If we sign up, can we still opt out of any CHPSO activity? Yes, you can choose which activities you participate in. Everything is voluntary, even after signing a contract.

What are "common formats?" The PSO rule envisions the aggregation of deidentified reports from PSOs to develop a National Patient Safety Database from which we will learn how to make care safer for our patients. The common formats allow the aggregation. AHRQ developed the formats through a national consensus process. Current incident report system users should find the common formats easy to use.

When we work with CHPSO, can we discuss quality problems with other hospitals? Yes you can, and that information will continue to be privileged and confidential. However, you cannot identify any of the providers without a signed consent from that person.

If another hospital tells us of an incident there, can we share that information with our workforce? Yes, but with these conditions: 1) you do not identify the hospital or any of the named providers (except with written consent from each that you identify); 2) you do not identify the patient; and 3) you only use that information for quality-improvement and patient-safety purposes.