Are We Safe Yet?

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Speaker Disclosure

• I do not have a vested interest in or affiliation with any corporate organization offering financial support or grant monies for this continuing education activity, or any affiliation with an organization whose philosophy could potentially bias my presentation.

About me

• I am married to a physician and have a sister who is a nurse.
• I am educated.
• I am a good pharmacist.
• I have a story to tell you.

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…and this is my story

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Medication Safety

A journey…. not a destination

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Institute of Medicine’s To Err is Human, 1999

• Errors are common
• Errors are costly
• Systems cause errors
• Errors can be prevented
• Medication-related adverse events are the single-leading cause of preventable errors

Editors Janet Corrigan, Linda T. Kohn, and Molla S. Donaldson

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The Numbers per Year

- 1.3 million injured by treatments intended to help
- 180,000 die as a result of medical accidents
- 2/3 preventable (i.e. due to errors)

Compared to your chance of dying on an airplane:
1 in 3 million

Boeing 747

- 450 would have to crash every year to equal medical deaths
- That’s more than ONE A DAY!

Institute of Medicine’s
Crossing the Quality Chasm, 2001

“Indeed, between the healthcare that we now have and the healthcare we could have, lies not just a gap, but a chasm.”

Crossing the Quality Chasm:
A new health system for the 21st century

IOM 2001 Report

The 1999 IOM report “summarized the information we had and got widespread attention.
“But afterwards, people were left with the task of trying to figure out what to do to improve patient safety.”

Dr. David Bates 2002

Institute of Medicine’s Preventing Medication Errors, 2006

- Electronic prescribing (CPOE)
- Use of technology (barcode scanning)
- Medication reconciliation
- Adoption of a safety culture
- Decision support and use of smart pumps

Institute of Medicine: 2006

- Communication of drug information
- Access to automated point of care drug information
- Monitoring for errors
- Communication of risk/benefit information
- Segregation of “look alike-sound alike” drugs
And now we have:

• IHI – 1991
• ISMP – 1994
• NCCMERP – 1995
• NPSF – 1997
• Joint Commission National Patient Safety Goals - 2003
• WHO Patients for Patient Safety/World Alliance - 2006
• CMS (on steroids)

Public awareness

• Medical errors are now dinnertime discussions

Anyone smell a rat?

Where do you begin?

• Creating a culture of safety
• Out with the old … in with the new

Isn’t this cute?

Canada Goose
Aviation Industry

1. Assume errors and failures are inevitable
2. Standardize procedures (i.e., pilot checklist)
3. Training, examination, certification procedures are highly developed and strictly enforced
The Culture Movement

• 1st: blame and shame
• 2nd: blame-free
• 3rd: no blame, but not no responsibility
• 4th: just culture

Defining a Just Culture

Workers trust each other, are rewarded for providing safety information, and are clear about their responsibilities regarding safe behavioral choices.

Creating a Culture of Safety

• Culture change does not happen overnight
• Tell stories
• Engage and empower the staff
• Communicate 8 times 8 ways
• Leadership must be immersed
• Free culture survey: http://www.ahrq.gov/qual/patientsafetyculture/
• Study together – Book Club
• Kotter’s Change Model

Types of behavior involved in errors

• Human error = someone blinked
• At-risk = “nothing’s happened yet”
• Reckless = making a conscious choice
• Malice = intentional harm
What to do?

- Human error
- At-Risk behavior
- Reckless behavior
- Malice

Emily’s Law

Vision for Medication Safety

Create your team

- Medication Safety Committee
  - Extremely interdisciplinary:
    - MD: Administration
    - RPh: RN
    - IS: Marketing
    - Dietary: Quality/Risk
    - Respiratory: Anesthesia
    - Surgery: Children’s Services
    - Educators: Patients

Initial step

- Count the number of steps in the medication delivery process
  - Every step represents a chance for error
  - Theory of Swiss Cheese
  - Reduce the steps, reduce the chance for error
Where errors occur:

- 39% prescribing (50% intercepted)
- 12% transcription
- 11% dispensing
- 38% administration (2% intercepted)

ISMP Self Assessment

- Patient information
- Drug information
- Communication of drug orders
- Drug labeling, packaging and nomenclature
- Drug standardization, storage and distribution
- Use of devices
- Environmental factors
- Staff competency and education
- Patient education
- Quality processes and risk management

Error-reduction Strategies: System

- Forcing functions
- Barriers and fail-safes
- Automation and computerization
- Redundancies
- Standardization and protocols

Error-reduction Strategies: People

- Rules and policies
- Education
- Information
- Performance shaping factors (checklists, reminders)
- Standardization and protocols

James Reason:

“We cannot change the human condition, but we can change the condition under which humans work”
Measurement

- Measure any change for validation
- Institute for Healthcare Improvement
  - Global Trigger Tool
  - Calculates rate of harm
  - Medication Module
  - Care Module
  - Surgical Module
  - Intensive Care Module
  - Perinatal Module
  - Emergency Department Module

Trigger Tool Practical Use

- Trigger Tool establishes a baseline of adverse events for a hospital
- Adverse events categorized and prioritized
- Resources focused on those events causing greatest harm
- Effect of interventions measured over time

Harmful Events Per Day

Event Reporting

- Must have option to be ANONYMOUS
- Keep it simple and easy
- Elicit thought-provoking ideas
- Celebrate high reporters
- Provide immediate feedback
Promote reporting of ALL events

- Risks/potential errors
- Near misses/close calls
- Errors that occurred but no harm
- Errors that occurred with harm

Paralysis with Analysis

- Reports alone cannot change anything
- Be specific with categories to report on
- Limit choices of categories so it's useful information

Don’t fall into the trap of overanalyzing EVERY SINGLE REPORTED ERROR to death!

When you overanalyze, you:

...Miss the big picture
- Miss opportunity to recognize trends
- Get stuck with analysis, no energy/time for ACTION
- Fail to apply lessons to other risks
- Bore people to death in meetings
- Paralyze enthusiasm about change

Categorization of errors

- Unauthorized drug
- Extra dose
- Omission
- Wrong patient
- Wrong dose
- Wrong route
- Wrong time
- Wrong dosage form
- Wrong technique
- Pharmacy preparation/dispensing
- No clinical indication (or incorrect indication)

ISMP ASSESS – ERR™

- Medication System Worksheet
Think about it…..

- What do reported errors really measure?

CULTURE

Practical online help

- ISMP Medication Safety Alerts: www.ismp.org
- ISMP Quarterly Action Agenda: www.ismp.org
- www.justculture.org
- www.consumermedsafety.org
- IHI Global Trigger Tool: www.ihi.org

When it all goes wrong

- With error
- Without error

Patients experience 2 types of disappointment:

- The disappointing unanticipated medical outcome
- The disappointing way the healthcare providers behave after the unanticipated outcome

Which are they more likely to forgive?

Most often…

Safety is commonly thought of as the absence of adverse events.
Begin to think that...

Safety is defined as the organizational capacity to protect from the potential of minor mishaps developing into major breakdowns

Roger Resar, MD

Don Berwick, MD idea for change...

- When harm is underway, proceed urgently to stop it, test possible solutions and learn from these
- Reconsider our attitudes toward thresholds for action