



From Intention to Outcome

Things You Can Do Tomorrow To Manage What's On Your Mind Today

Barbara L. Olson, MS, RN, FISMP

@SafetyNurse

Disclosure

- Barbara L. Olson, MS, RN, FISMP is a seasoned nurse and patient safety expert who serves as the Director of Patient Safety in the Clinical Services Group at HCA in Nashville, TN.
- Ms. Olson completed a one year Safe Medication Management fellowship with the Institute for Safe Medication Practices and sits on the Board of the American Society of Medication Safety Officers.
- She maintains a blog, "On Your Meds: Straight Talk about Medication Safety" which reaches an interdisciplinary audience on the Medscape platform.
- Ms. Olson received an ISMP Cheers Award in 2010 for her work promoting medication safety in social media.
- She passes along high end patient safety-sensitive information on Twitter (@SafetyNurse).

Happy New Year!



Patient Safety

- The *science* of making certain people are not harmed as a result of their need to seek care or the way we deliver care.

Temporal Trends in Rates... North Carolina Study

- 10 NC hospitals
- 2002-2007
- trigger tool methodology
- harm rate: 25 patients per 100 admissions

<http://www.nejm.org/doi/pdf/10.1056/NEJMsa1004404>

Adverse Events in Hospitals... OIG Report

- Medicare beneficiaries, hospitalized 10/08
- review of 780 closed medical records
- incidence of preventable adverse events 7.4%

<http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>

Safety Data Points

Take-aways

- The incidence of medical errors largely unchanged since IOM report
- We are counting differently (things like HACs, once seen as the cost of doing business) are now in the denominator
- Largest areas of opportunity: Infection Prevention; Medication Use; Patient Care
- Causation: Medical judgment; skill; management, (particularly *medication prescribing* and *administration*); ineffective delivery of planned care (delays); assessment and monitoring lapses

Analysis

- We are probably safer
 - <http://www.washingtonpost.com/wp-dyn/content/article/2010/12/20/AR2010122004669.html>
- We need to continue and accelerate efforts to transform how care is delivered
 - http://www.nytimes.com/2010/11/25/health/research/25patient.html?_r=2&ref=hospitals
- The NC article was the #1 retweet under the #ptsafety hashtag on Twitter over the Thanksgiving weekend

The Paradigm of Intention



- “First, Do No Harm”
- “Follow the 5 Rights”

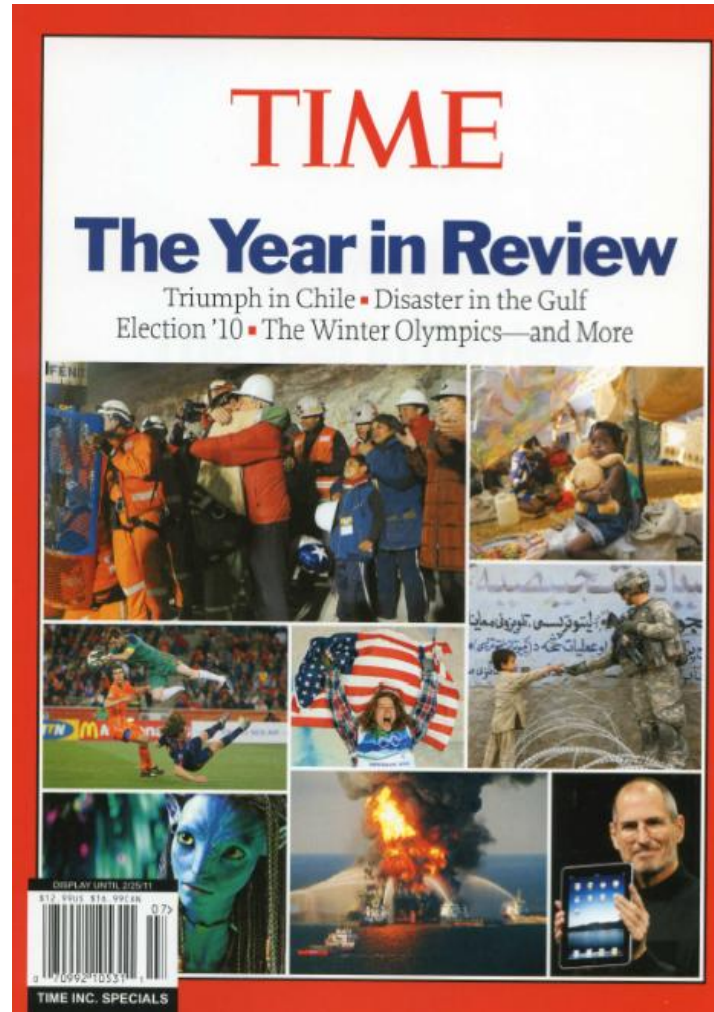


WHAT'S WRONG WITH US?



THINK

Mistakes in 2010



Mistakes in 2010

- Dustin Johnston, a pro golfer, is positioned for a 3 way first place tie in a major tournament.
- He grounded his club in a bunker, believing the maneuver to be legal.
- It isn't, and he is fined 2 strokes, finishing tied for 5th place.

http://www.amazon.com/Time-Annual-2011-Year-Review/dp/1603208690/ref=pd_sim_b_18

Errors of planning

- Knowledge-based
- Shored up by:
 - Clinical decision support
 - Evidence-based care
 - Standard approaches to care
 - Availability of patient information, drug information

Errors of execution

Error Prevention

Mistakes in 2010

- Jim Furyk, a PGA top golfer, sets the alarm on his cell phone.
- The battery dies as he slumbers.
- Furyk over-sleeps his tee time and is disqualified.

http://www.amazon.com/Time-Annual-2011-Year-Review/dp/1603208690/ref=pd_sim_b_18

Errors of planning

- Knowledge-based
- Shored up by:
 - Clinical decision support
 - Evidence-based care
 - Standard approaches to care
 - Availability of patient information, drug information

Errors of execution

- Process deficits
- Driven by:
 - Inadequate systems (means to the end are not robust, reliable)
 - Slips, trips, lapses

Error Prevention

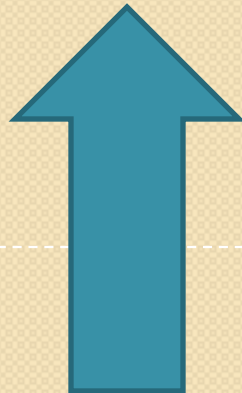
Complexity in Healthcare

- Volume of
 - diagnoses (13,000)
 - drugs (6,000)
 - treatments (4,000)
- Patient diversity
 - genetic/gender differences
 - age and developmental considerations
 - diversity of expectations.... a good birth or a peaceful death may not look the same to all people

Reliability

System Design

- Barriers
- Redundancies
- Recovery Ops
- Awareness of human fallibility ~ limitations of human performance



Human Performance

- Adherence to organizationally defined, evidenced-based practices, or safest practices
- Management of at-risk behaviors
- Safeguards to prevent reckless behavior



Over-Reliance on Human Vigilance

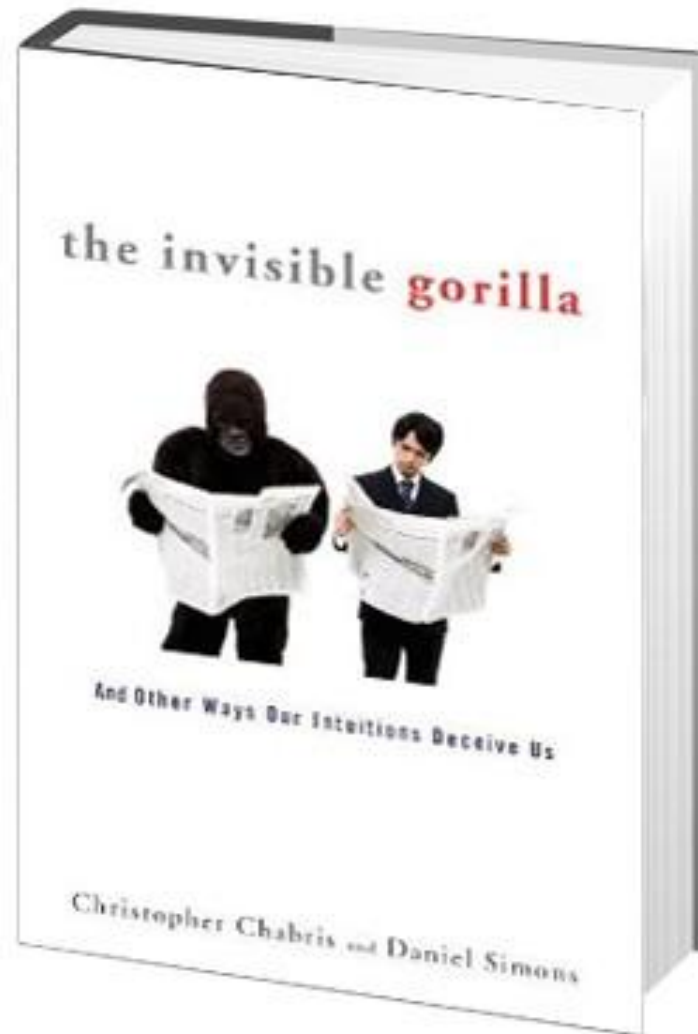
Incomplete
Understanding of
Human Cognition

i cdnuolt blveiee taht I cluod aulacly
uesdnatnrd waht I was rdanieg.
Aoccdrnig to rscheearch at Cmabrigde
Uinervtisy, it dseno't mtaetr in waht
oerdr the ltteres in a wrod are, the olny
iproamtnt tihng is taht the frsit and lsat
ltteer be in the rghit pclae.

Confirmation Bias

Accept information that agrees with our hypothesis; reject information that does not

The Invisible Gorilla



http://www.theinvisiblegorilla.com/gorilla_experiment.html

Inattentional blindness

Inability to perceive input that is unexpected even when it is visible; unique stimuli does not fit into a familiar mental model.

“Looking without seeing”



DRUG SHORTAGE

What Influences How Humans Perform

- Vision and hearing abilities
- Stress
- Fatigue
- Lighting
- Temperature
- Distractions
- Group dynamics
- Culture



SHAPE

What Frontline Leaders Can Influence

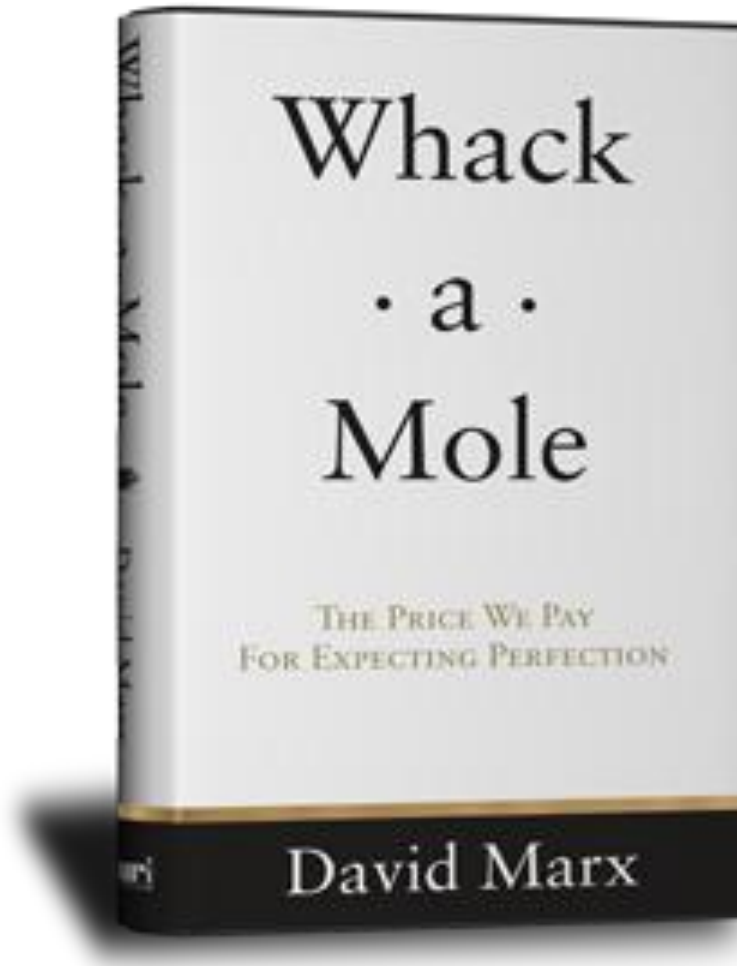
Systems Used
by Clinicians



Behavioral Choices
of Clinicians

Outcomes—good or bad—are the result of these forces.

Whack-A-Mole



<http://www.amazon.com/Whack-Mole-Price-Expecting-Perfection/dp/0615283071>

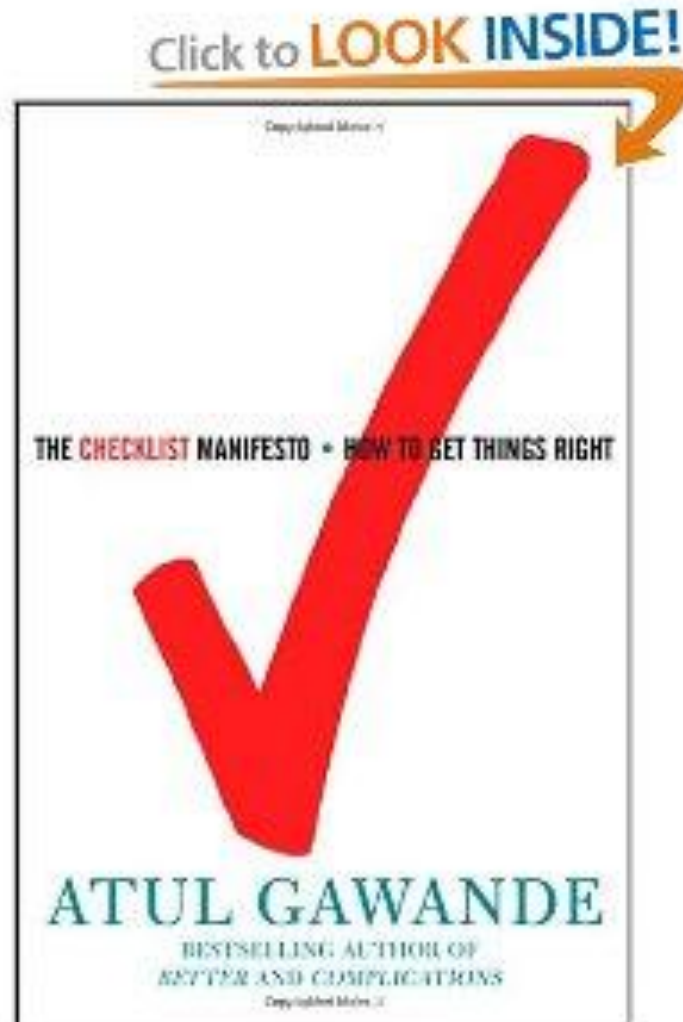
ISMP's Rank Order of Risk Reduction Strategies



ISMP's Rank Order of Risk Reduction Strategies



Gawande on Checklists



<http://www.amazon.com/Checklist-Manifesto-How-Things-Right/dp/0805091742>

TJC's 2011 NPSGs

- **Goal 1 Improve the Accuracy of Patient Identification**
 - Use at least two patient identifiers when providing care, treatment, and services
 - .Eliminate transfusion errors related to patient misidentification.
- **Goal 2 Improve the Effectiveness of Communication among Caregivers**
 - Report critical results of tests and diagnostic procedures on a timely basis.
 - Measure, assess, and if applicable, take action to improve the timeliness of reporting and receipt of the critical test results by the responsible licensed caregiver.
- **Goal 3 Improve the Safety of Using Medications**
 - Label all medications, other solutions, and medication containers (e.g. syringes, medicine cups, basins), both on and off the sterile field in preoperative and other procedural settings that are not immediately administered.
 - Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.
- **Goal 7 Reduce the Risk of Health Care-Associated Infections**
 - Comply with either the current Center for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.
 - Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms (MDRO) in acute care hospitals.
 - Implement evidence-based practices to prevent central line-associated bloodstream infections. • Implement evidence-based practices for preventing surgical site infections (SSI).

TJC's 2011 NPSGs

- **Goal 8 Accurately and Completely Reconcile Medications across the Continuum of Care** (Note: All requirements for Goal 8 are not in effect at this time.)
 - Compare the patient's current medications with those ordered for the patient while under the care of the hospital.
 - Communicate the complete and reconciled list of patient medications to the next provider of service, within or outside of the hospital.
 - Provide a complete and reconciled list of medications to the patient and/or family upon discharge from the hospital.
 - Perform modified medication reconciliation processes in settings where medications are used minimally or prescribed for a short duration.
- **Goal 15 The Organization Identifies Safety Risks Inherent in the Patient Population**
 - Identify patients at risk for suicide.
- **Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery**
 - Conduct a pre-procedure verification process.
 - Mark the procedure site.
 - Perform a time-out before the procedure.



FORGIVE

Mistakes in 2010

- Armando Galarraga is one out away from pitching a perfect game when Jim Joyce, a seasoned and respected umpire, made a bad call.
- Joyce repents and Galarraga forgives.

http://www.amazon.com/Time-Annual-2011-Year-Review/dp/1603208690/ref=pd_sim_b_18

What You Can Do Tomorrow

1. Champion processes that allow the strengths of humans to shine; guard against processes that can be predicted to break down when the acts of one person fail
2. Influence those in your sphere, mostly through coaching and by your example
3. Share stories, so that your colleagues can learn from mistakes made by others

do more
right things
right things
right things

do fewer
wrong things