Patient Safety

EXPERT ROUNDTABLE DISCUSSION

Moderator:

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Participants:

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Editor's Note: *Following is the fourth in a series of Roundtable discussions on the most compelling women's health and childbearing topics as part of* Lifelines' *ongoing 10th anniversary celebration. Listen in as leading experts talk about the advances that have been made in patient safety in recent years—and the work that still needs to be done.*

Susan Kendig: Welcome everyone! As you know, the Institute of Medicine (IOM) report that was released in November 1999 stunned the country by estimating that between 44,000 and 98,000 Americans die each year due to medical errors. The report estimated that medical errors were actually the eighth largest cause of death, which is really startling from a public health perspective. That report jumpstarted a patient safety movement, and today we'll talk about the impact that movement has had on nursing. How have you all observed or experienced this impact?

Kathryn J. Nelson: I'll talk from the perspective of a hospital patient safety officer. When the IOM report came out, I was working in a quality office and we were a pretty high–functioning quality office doing lots of patient population–based improvement, but patient safety wasn't really in the realm of what we were paying attention to until the IOM report was released. It opened our eyes and made safety a focus in quality offices at the hospital level. We began our safety work based on that report, saying we had to do things differently.

Kendig: What are some examples of how nursing was involved in that?

Nelson: First we asked the question, "Do we have information about safety in our facility right now?" And, of course, when you ask that question it leads you right to the incident reports that every hospital in the country has had for many years. We realized the majority of incident reports were being filled out by nurses. So nurses were the ones alerting hospitals to unsafe conditions via their incident reports. We then asked ourselves, "How should we act differently based on these reports? What have we done in the past and how should we be paying attention to them in the future to prevent these incidents?" When you ask those questions, it leads you directly into prevention activities based on what you hear from the frontline staff. The majority of frontline staff who were talking about unsafe conditions were nurses.

Windy Carson-Smith: I've observed that not only are we starting to shift a focus but we're also starting to create infrastructure in some institutions to promote evaluating quality. By that I mean some nursing committees and nursing governance structures in hospitals have shifted toward safety as focus. As Kathryn indicated, the quality assurance officers are starting to look at reports more carefully and analyze them. Also, nurses are becoming more mindful. Also, Agency for Healthcare Quality in Research has a database related to evidence-based practice guidelines at http://www.guidelines.gov. As a result of all this, institutions and programs such as the Magnet Program of American Nurses Credentialing Center are starting to include quality as they evaluate the structure, governance and nursing practice of hospitals as they develop certifications. Nationally, we have National Database of Nursing Quality Indicators (NDNQI), which is looking at quality indicators. But with a shift toward looking at quality, it's making it easier to get the necessary data associated with the indicators. NDNQI is a program that American Nurses Association (ANA) developed with the University of Kansas, starting in 1994, to track quality data. A proposed 21 measures of hospital performance were established, and they were to link quality with the availability of nursing services in acute care settings. As a result of that program, they started with a pilot study from 1997 to 2000 that was funded by ANA to test selected indicators. When NDNQI was started, the program was designed with hopes that eventually nurses around the country and hospitals would join the program; what we've seen is they're joining in exponential rates right now. It's an interesting phenomenon because they actually have to pay a fee to join and then someone must participate in collection process. And now it seems that everyone's interested in participating in this process. Before, hospitals were slow to join, but now the program has become very popular. I do have a concern, however, because while the IOM report asked for and indicated that it wanted to create a culture of safety and nurses have done a lot of the reporting in the process, in some hospitals and institutions, individuals are penalized when they start to report instances where there are concerns about quality and safety. Some managers—not all managers—but some managers are more concerned about budgets as opposed to safety.

Nelson: There are a couple of things I can add here. It's true that we're developing more infrastructure around safety. I don't think we had as many patient safety officers in institutions before the IOM report, so just having jobs designated for patient safety is important. After the IOM report, the expert advice was to "create a culture of safety with an emphasis on a nonpunitive culture," and so forth. It's tough to determine what that culture is and what it looks like. It's even tougher to figure out how to make it real, where it's comfortable to bring up failures and mistakes. I think we've been trying in the five years since the report was released to say, "What does that look like in our organizations and how do we do this in a way that makes sense?"

Kendig: With the current malpractice crisis, one of the high-risk areas we keep hearing about is OB/GYN. AWHONN has really been leader in promoting safety in OB/GYN, such as with

fetal monitoring courses and evidence-based guidelines. My background is women's health, and what I see in nursing is the move toward evidence-based guidelines that give nurses tools to use in promoting quality outcomes and safety. Just yesterday I read a newspaper article talking about the American Medical Association developing quality measures of medical care and working with Congress to develop more than 100 standard measures of performance that will be used by the government to improve quality of care. It really takes a team working together to promote quality outcomes and it's critical for nurses to have a place at the table when interventions to promote safety are discussed.

Kendig: Would anyone like to comment on how the issues surrounding patient safety are different for advanced practice nurses (APRNs)?

Nelson: In many ways, APRNs became the leaders around our safety efforts because they were tied to patient populations within the hospital. So we really relied on them heavily in our safety program. They were leading a lot of the safety practices going on at our facility.

Carson-Smith: APRNs are the key to looking at evidence-based practice. Under the guise of collaboration, physicians have implemented changes to compel "supervised" practice. With evidence-based practice, it frees up the nurse to work within parameters that we know are tried, tested and true. They give the nurse something of substance to work with. The same holds true in terms of how hospitals are organized and structured in many instances. It's not necessarily about the best way to practice nursing care. And we must get away from a model of care that is intended to support physicians' practices as opposed to a model of care that highlights and emphasizes the best education and clinical skills of nurses at the bedside whether they be registered nurses (RNs) or APRNs.

Kendig: Often, when we talk about the patient safety movement we focus only on the hospital setting, but the majority of APRNs, nurse practitioners and certified nurse-midwives practice in primary care settings, where a significant number of errors can occur. The difference is the type of error that occurs in different practice settings. Patients are more acutely ill in the hospital and therefore more likely to die, more likely to have the wrong surgery, and so forth, because that's what happens in hospitals. In the primary care setting, people tend to fall through the cracks in terms of misdiagnoses, lab work not being followed up, referrals not being followed up, and so on. All those things lead to increased health care costs, poor outcomes, and ultimately could lead to patient safety issues and poor outcomes in the hospital setting. So I think it's important to look not only at the hospital but also at the primary care setting.

Karen Adkins-Bley: I agree. The IOM report focused on hospitals, but there is so much that goes on out there in ambulatory care settings and even in home care.

Kendig: How are organizations such as hospitals, health systems and nursing organizations supporting nurses in moving patient safety initiatives forward?

Carson-Smith: There are so many patient safety initiatives going forward right now that are amazing. A big one going on at ANA is a safe patient handling initiative. During the first year that legislation was introduced on this topic, there were actually three bills passed related to safe patient handling, in Texas, New York and Ohio. This is a classic example of evidence-based practice. For years, nurses were taught to lift patients even though there was no evidence that lifting was safe. Once we'd done the research, we found that, in reality, no matter what you do or how you move your body, some patients are just too big to be lifted. And so now we're seeing no-lift policies or utilization of lift devices or lift teams because back injuries are the number one injury related to workers' compensation in nurses. There are also initiatives regarding chemical exposure in the workplace. ANA has a survey on their Web site related to nursing exposure to chemicals in the workplace. The removal of mercury in hospital workplaces is another issue. There are so many things going on related to safety it's amazing. But when you talk about evidence-based practice, you want to address nurses at the bedside but you've also got to address what's occurring in the hospital setting and some of these things we've just got to step back from and think about.

Adkins-Bley: As Windy was saying, not only are organizations supporting patient safety initiatives, but they're also promoting the safety of caregivers. I think the organizations are really stepping forward when it comes to patient safety. Hospitals, as well as health systems and the different nursing organizations, are really looking at the patient safety initiative and I think there's teamwork going on.

Kendig: Can you talk a little bit about what's going on from a hospital perspective regarding the support of nurses in the patient safety initiative?

Adkins-Bley: We're developing nursing teams here at our organization. We have nursing excellence, and we're looking at the patient safety initiative in different areas, such as medication handling. We're re-evaluating our policies and procedures, and the hospital is strongly supporting going toward evidence-based practice within nursing.

Nelson: I worry a little bit about whether, as an industry, we're doing a good enough job supporting nurses around safety. Because when you think about it, nurses are right at the sharp

edge of where the caregiver meets the patient and where mistakes can happen. And so I worry that we're not doing enough to support them to deliver safe care—that our systems and processes are robust, that they work in systems that make sense to the frontline caregiver and that we support them if a mistake happens because it can be devastating to careers when mistakes happen. And I worry that maybe nurses are being expected to be hypervigilant protectors of patients—that the nurse is being put in the role of protecting the patient from the harm that the system might cause. I know we're doing a lot more now than when the IOM report came out, so in these five years we've made tremendous strides, but I still worry a little bit that the workforce needs to be more supported when it comes to delivering safe care.

Carson-Smith: Even since the report came out, we still have problems with staffing. Because, a lot of times, nurses are just tired or overworked—they have too many patients. So we need to make sure we're evaluating clinical practice just within that context, but we've got to get back to asking, "What is the environment? How many people are nurses actually caring for?"

Kendig: Your points together are well taken because not only do we need adequate numbers of nurses at the bedside, we need them to do what nurses do and to work within their full scope of practice. Having inadequate numbers of nurses and placing nurses in situations where they must be hypervigilant and the last line of defense before errors occur, without allowing those tools, can stall an initiative moving forward.

Kendig: Do you think that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommendations have impacted patient safety initiatives and how so?

Nelson: What I appreciate about JCAHO is that they've said we're going to have national standards for patient safety. So across every facility in this country, if you're a patient there, there are going to be certain requirements for keeping patients safe. I appreciate the safe standards that we're using. JCAHO pushed that and made it happen.

Carson-Smith: Look at legislation out there. A lot of states are creating mandated nurse centers, and as a result of nurse centers being legislatively enacted, in addition to them focusing on staffing, they're also focusing on patient outcomes and clinical practices. So it's not just a focus on those particular issues and concerns, and I think it's exciting.

Adkins-Bley: I agree with Kathryn. It's good to see that in working toward national patient safety goals, it's not, "We have to do this because of JCAHO," but rather it's a standard that's out there that we're expected to be meeting.

Kendig: What about sentinel event reporting systems? Is that helpful in terms of bringing new information to the surface in terms of safety?

Nelson: When I was a safety officer, I felt frustrated that we were all learning about hazards and how to prevent harm to patients independently of each other. If something happened in our facility, we'd learn something, but it was difficult to share those lessons across hospitals or health systems. So having voluntary reporting system through JCAHO is one vehicle for us to be able to learn from each other. It's a good thing in that it's teaching us about other hazards that maybe we haven't experienced ourselves. We need much more of that learning as a community.

Kendig: An integral part of nursing practice is communicating with patients—giving information to patients and their families and eliciting information from patients. What are the safety issues we need to be thinking about with regard to patient communications and health literacy?

Carson-Smith: We just need to get the information out there in the universe. What I've heard from nurses around country is that even the RNs at the bedside have certain communication skills where they are able to elicit information and it's the transmittal of that information either via the nursing notes or speaking directly with the primary care provider where disconnect occurs. In many instances, the nurses are able to get the information but others don't hear the information and that frustrates them.

Adkins-Bley: With regard to the information exchange, I think we have to be careful about what information patients are getting out there. There has to be some consistency among lots of different things because people are very technologically savvy and they come in and they say, "I found this on the Internet," and that type of thing, so we have to see what's available out there to people.

Nelson: We have to figure out as an industry how to be more open and forthcoming about safety information with patients. How do we engage patients and their families about patient safety? That's a pretty important piece to figure out.

Kendig: At the most basic level, all health care providers are communicating with patients on a daily basis and with patients and their families about things like self-care, recommended therapeutic regimens, the course of their hospitalization, what to expect in surgery, and so forth. Sometimes how we communicate these issues is a patient safety issue. As health care providers, we know what it means when we say to take a medication three times a day, but to the patient does that mean to take it at 7:00, 7:10 and 7:20 a.m. before leaving for work? Does it mean

taking it every eight hours? What does it mean to the patient and how is it going to happen? Then there are people having surgeries that they don't really understand because there are so many forms to complete. They may not understand the forms and they might be agreeing to something they don't understand, simply because it's been spoken in our language as opposed to a language they can understand. Someone brought up the issue of hand-offs in terms of communication between members of the health care team as an area of concern. And there is always what I like to call, "playing well with others"—the simple communication between health care providers as colleagues rather than as a blame-oriented or hierarchical system. Everyone has a role in promoting safety and therefore what everyone says is important in the hand-off. Does anyone have anything to add here?

Kendig: Across health care we're trying to adopt some of the safety practices from the aviation industry. Crew resource management (CRM) training is one aviation safety practice that some health care organizations are exploring. CRM is a form of team training, which emphasizes better ways to communicate. For example, one basic principle is that every member of the team, regardless of rank or hierarchy, has the right and duty to speak up if something's unsafe. To truly improve safety, we'll need to focus on those interpersonal behaviors and how they relate to delivering safe care and not just focus on improving equipment or technology. We're lucky we can look to other industries like aviation and nuclear power to see what's been successful there.

Kendig: Well, five years have passed since the IOM report and a few of you have alluded to this—we're a little bit better off and we have more of an awareness and we're starting to look at how we can put mechanisms in place to improve safety and quality. What do you think our greatest challenges are for the next five years? What's the next step?

Nelson: One worry is that we're just sort of co-opting the language of patient safety and not making a lot of real change. For example, talking about safe systems instead of truly fixing systems.

Kendig: So what's the next step to keep us going in the right direction?

Nelson: I believe that we're going to have to be much more open and sharing about the hazards that we're finding in our hospitals and in our primary care settings, and so forth. We need to be much more willing to say, "This is a risk and here's how we fixed it" because we shouldn't all be re-creating the wheel. Of course, transparency brings with it a whole set of barriers such as shame, embarrassment, fear of litigation, and so forth. But if we can be much more open and transparent about the hazards we're finding and how we're solving them, then we can move faster in fixing things.

Kendig: So basically the JCAHO sentinel event reporting program is a start but not the endpoint.

Nelson: Yes. The aviation industry has a very strong tradition of near-miss reporting, so that they can learn about risks *before* there's a plane crash. We should look to that model and be much more proactive about looking at risks and near misses and getting that information out.

Adkins-Bley: Nursing has to be careful that the burden isn't all on nurses. We all need to work as a team and identify who might be the right person to handle steps in order to implement those safety measures or to do monitoring. It shouldn't always be put on nursing, but rather, having nursing push back and say, "Let's look at this as a team and see where we can be involved."

Kendig: So keeping nursing at the table?

Adkins-Bley: Yes.

Kendig: What about the role of patient safety in nursing education?

Carson-Smith: Nursing education has changed considerably from what I've heard about it (keep in mind that I'm not a nurse; I've just worked with nurses forever). And it's exciting to see what's occurring. The problems relate to getting everybody on board with regard to safety. It's a changing of a mindset. I think that nurses are taught that there are other factors that impact on it.

Kendig: I've been working on a patient safety curriculum for nurses because, as an educator, I strongly believe that we need to be educating the health care providers of tomorrow. Going down the path of the curriculum we've always used and then introducing patient safety concepts after graduation seems to be counterintuitive to creating a culture of safety. I think patient safety has always been integral to nursing education because as was pointed out earlier, we are the ones at the bedside, at the sharp edge where harm can occur. So nurses have always been educated to watch for medication errors, making sure people are going to the right surgery, and so forth. The IOM report actually recommends that five key concepts be included in health care provider education:

1. The delivery of patient-centered care—really understanding what that patient wants, what this issue means to the patient and how to work with the reality of the patient's life to reach the desired outcome.
2. Functioning as members of an interdisciplinary team, which goes to the communication issues we talked

about—recognizing that everyone has a key role in the care of the patient.
3. Evidence-based practice—not doing things the way we've always done them, but rather looking at what the research is telling us, so that our care can reflect current, cutting-edge best practices.
4. Looking at quality improvement approaches as we've talked about—when we identify areas where harm can occur, thinking about what we can do to improve quality.
5. The last concept is informatics—we often think about informatics as simply the technology (e.g., electronic medical records, electronic ordering systems). From an education perspective, the use of informatics means knowing where to go and how to find information. So teaching our students not only the latest and greatest in terms of the technology but really how to find and utilize resources that are going to support their care and their practice.

Nelson: I agree. We should be training the future generations of health care workers and making sure that the curriculum has formal safety activities, such as human factors engineering and root-cause analysis. There are nursing programs around the country that are being innovators around that. Sue, you're one who's doing it! We shouldn't be graduating students without a good understanding of patient safety. It needs to be put into the curriculum as they are being trained.

Kendig: All our colleagues in health systems have a role in educating the health care providers of tomorrow, such as providing preceptorships—places for students to sit on quality improvement committees or safety committees, so they actually grow up in a culture of safety as opposed to being sort of plunked down into it after graduation.

Kendig: Any final thoughts?

Carson-Smith: We need to get safety into the underwriting process as well. It's so critical that we start getting insurance companies to pay for quality-based practices and to look at whether or not the nurse is practicing correctly when they underwrite malpractice coverage (rather than spend so much time on the lawsuits themselves). So it's the underwriting of malpractice insurance in an appropriate fashion and then looking at the practices associated with health insurance to promote.

Nelson: I hope we can keep the momentum going to make strides toward "ultra" safe care and not lose the focus we've gained since the IOM report came out.

Get the Facts

American Nursing Credentialing Center: http://www.nursingworld.org/ancc/

National Database of Nursing Quality Indicators: http://www.nursingquality.org

IOM Report: *To Err is Human*, National Academies Press: http://www.nap.edu/books/0309068371/htm