

# The Safety Net: Creating a Comprehensive Culture of Safety

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The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) National Conference on Quality and Safety in Health Care took place December 11–13, 2002 in Chicago, IL. More than 398 healthcare professionals attended to learn about practical tools and strategies for designing and implementing a culture of safety in their respective organizations.

Programs focused on building system-wide safety programs; best practices and potential pitfalls; safety tools; and resources for change. Preconference workshops addressed issues of the Joint Commission survey process and a Failure Mode and Effects Analysis (FMEA) workshop.

“Shared Visions—New Pathways: Survey Process Changes Effective 2004,” a presentation of the Joint Commission Accreditation Services, provided an overview of the forthcoming modifications to the survey process; in addition to using presurvey data aggregation from critical focus areas to assess the impact on patient safety or quality of care (i.e., CFAs). CFAs are what we, as healthcare professionals, know as topical standard areas, such as credentialing, information management, and rights and ethics. Changes will also incorporate a systems approach to survey using a tracer methodology. This approach will trace a number of patients through the organization’s entire healthcare process.

An update on 2003 accreditation standards and survey processes was also provided by the Joint Commission Director of Standards Interpretation/Office of Quality Monitoring. Emphasis was placed on linking staffing to outcomes, while recognizing that the Joint Commission does not prescribe staffing levels for organizations. Pain management, medication management, and emergency management standards were reviewed with a summary discussion of Joint Commission’s National Patient Safety Goals and Recommendations. The take away message—for survey scoring, all healthcare organizations must implement all Joint Commission patient safety goals and

recommendations that are relevant to services provided, or implement an acceptable alternative(s). Failure to address one or more of the national safety standards will result in a single “Special Type 1 Recommendation.”

The director for strategic initiatives, Joint Commission and a Joint Commission Resources consultant discussed the application of proactive risk reduction (i.e., FMEA), as opposed to reactive root-cause analysis, when an error is made. The speakers concluded with emphasis on the principles of safe design for systems and processes (i.e., prevent failure, protect the patient from failure, and mitigate the effects of failure).

The conference began with keynote speaker John Nance, a licensed attorney and decorated Air Force pilot. An established speaker on topics such as teamwork, risk management and motivation, Nance inspired the entire audience as he spoke of “Enhancing Patient Safety Through Teamwork Solutions.” A founding board member and current member of the executive committee of the National Patient Safety Foundation (NPSF), Nance is a strong advocate of human factor relationships in safety and a strong advocate of the team concept when addressing complex, interdependent tasks, such as those regarding healthcare.

Many speakers provided case examples and lessons learned with patient safety and provided meaningful take away messages. Robert Krawisz, the executive director of the NPSF, supported his presentation with a personal remembrance of his daughter and other friends’ experiences while they were patients in a healthcare facility. His message suggests that the craft based culture of healthcare, which includes rigid hierarchies, often accounts for clinical care systems being designed in isolation of the clinician. Krawisz, among others, sent a message that supports honesty in dealing with patients and families when errors occur, and places emphasis on communication with patients and family—truly integrating them into the care process.

Two panel presentations provided excellent discussion on issues of patient safety, including safe medication use, emergency department strategies, staffing, and safety and physician engagement in the survey process and the effect on patient safety. Take home messages included the following:

- Emergency departments should assume errors will occur and redesign systems to make errors more difficult; make errors obvious before they affect patients; and provide “buffers” to minimize the effects of errors on patients.
- Medication management will help address error-prone processes, high-risk populations, and high-alert medications.
- Staffing and Safety. Lift teams will significantly reduce workplace injuries and will significantly affect patient safety by reducing patient falls.
- Engaging physicians in the survey process enhances the relevance of accreditation to physicians by engaging them in the accreditation process.

Key themes throughout the conference included the following: Lead proactive improvement efforts; conduct periodic self-assessment of safety; engage the patient, family, and community in patient safety; and most importantly, develop and implement teamwork.

The culmination of organizational efforts in quality and patient safety was brought to light during the presentation of the 2002 Ernest A. Codman Awards. The award honors Ernest A. Codman, a physician, who is considered the “father of outcomes measurement” in healthcare. These awards represent the highest achievement in performance measurement used to improve the quality of healthcare provided to the public. Organization awards honor Joint Commission accredited healthcare organizations that have demonstrated improved performance through process and outcomes measures. The individual award recognizes an individual who has played a significant leadership role in promoting the use of performance measures to improve healthcare services, made major contributions to the development and testing of performance measures, or significantly enhanced the science and art of quality improvement. Award recipients were honored with a dinner ceremony and each organization

recipient provided an overview of their organization and accomplishment. Award winners included the following:

- Behavioral Healthcare—Sinnissippi Centers, Inc., Dixon, IL; *MISA Service Enhancement to Improve MISA Consumers’ Quality of Life: A Study Comparing Service Access Enhancement to Improved Consumer Functional Levels*
- Hospital—Children’s Hospital and Health Center, San Diego, CA; *Clinical Pathways: A Quality Improvement Initiative to Provide Optimal Care*
- Long-Term Care—Marwood Nursing & Rehab, Port Huron, MI; *Effective Pain Management in Long-Term Care*
- Multiple Organization—Greater Dayton Area Hospital Association, Dayton, OH; *Hospital Performance Reports Project*
- Iowa Health System, Des Moines, IA; *Diabetes Statewide Initiative.*

The Individual Award was awarded posthumously to John Eisenberg, MD, MBA, former director of the Agency for Healthcare Research and Quality. Eisenberg, who died in March 2002, emphasized the role of researchers in the field of improving safety and reducing medical errors. He spearheaded the federal government’s response to the Institute of Medicine’s 1999 report on medical error and became the nation’s spokesperson for patient safety. He was at the forefront of the Secretary’s Patient Safety Task Force, the President’s Advisory Commission on Consumer Protection and Quality, and the Quality Interagency Coordination Task Force.

Deborah L. Grubbe, corporate director, Safety & Health from Dupont, presented “The Goal is Zero: Leadership and Systems in Safety and Quality.” Most notably, she began her presentation stating that if this were a Dupont gathering she would begin with an announcement telling us to note the exit doors and where we would convene if evacuated. Then she described how we would hear a recording of the emergency evacuation bell or siren! Dupont has 80,000 employees in 210 sites. Its safety mantra is “Safety. After Two Centuries, It’s Still Our First Thought.” At Dupont, safety is a core value. Dupont believes all injuries are preventable, that management is responsible for preventing injuries, and working safely is a condition of employment. The Safety Triangle that was presented shows how 300,000 at-risk

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behaviors lead to 30,000 near misses, 300 recordable injuries, 30 lost time injuries, and one fatality. It is the base of the triangle—the at-risk behaviors—that Dupont targets through their safety programs and policies. Her closing point was “You will achieve the level of safety excellence you demonstrate you want.”

The conference ended with a timely and balanced moderated panel presentation on the role of the media in medical-error reporting. The question at hand was whether the public has a right to know about errors committed in medical facilities. The panel included seasoned and respected journalists and healthcare professionals and provided a balance of lessons learned from both perspectives. The messages I gleaned from this excellent discussion included the following: First, when an organization experiences a crisis event, the actions of the CEO speaks volumes about the culture and integrity of an organization. Next, always use honesty and candor when dealing with a patient if you make a mistake. Third, in reviewing the event, take a systems approach and deal with the consequences of the event without blame. Lastly, as a hospital administrator,

find a reporter who can earn your trust and develop a relationship with that reporter. The press represents the public and if they suspect you are covering up, you lose their trust. In other words, “It’s not about a *right* to know, it’s about a *need* to know.” Show the press what is being done and the press may be your best marketing tool.

The conference provided a refreshingly candid educational approach to addressing the emotional and challenging issue of medical errors and patient safety. It is clear that the medical community, medical professionals, and even the press have much to learn about the causes of medical error while working on issues of prevention. Lucian Leape, in a January 1999, article in the *Boston Globe*, summed up the emphasis on teamwork, systems analysis, and nonpunitive responses to medical error best. “Punishment is indicated for willful misconduct, reckless behavior, and unjustified, deliberate violation of rules. But not for error...”

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