Patient Safety

*How Can Residents Prevent Medical Errors & Improve Quality of Care*

Glenn Rosenbluth, MD
Director, Quality and Safety Programs, GME
Welcome
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors (and know what counts as a medical error)
Make the call…

Emergencies
Codes
Emergency release of blood
Need for help

Confirmation is essential
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors
- Avoid using unnecessary abbreviations
Abbreviations can be confusing

- IDK
- LMAO
- WTG
- FYEO
- IMHO
- K
Abbreviations can be confusing

- Neo
- CTX
- MR
- MRCP
- D/C, DC, D&C
- 2/2
- APAP
Abbreviations can be confusing

- Code situations are high stakes communication
  - Avoid abbreviations and brand-names
  - Example: “Neo” and “Levo” sound alike
    - UCSF preference: Phenylephrine and Norepinephrine

- CTX
  - Usually ceftriaxone, except when it isn’t
  - “0.01 per kg of epi”
    - Units???
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors
- Avoid using unnecessary abbreviations
- Complete Incident Reports
When should I complete an IR?

- Medical errors, adverse events
- Communication breakdowns that impact patient care
- Before or after talking with your attending
  not instead of talking with your attending
- Even if the nurse has completed an IR
UCSF (Parnassus, MTZ, MB)
SFGH

- **Patient-related incidents**
  - Enter through Invision/LCR
  - Access the patient
  - Click on “UO/Suggestion Box”

- **Non-Patient Related:**
  - Enter on intranet site: http://insidechnsf.chnsf.org
  - Click on the UO icon

- If it asks you to re-login, use your regular login
VAMC

- Report: Adverse events, close calls, risk-prone conditions
- Enter all patient-related incidents via CPRS
  - Select patient
  - Tools → More → QI Reporting
- Other incidents or no CPRS access?
What happens to Incident Reports?

- Reviewed by a real person
- Inquiries are made to get additional details
- Improvement activities and follow up plans are developed
- You may be contacted for follow-up

- Serious incidents are escalated for review and consideration of a Root Cause Analysis (RCA)
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors
- Avoid using unnecessary abbreviations
- Complete Incident Reports
- Attend a Root Cause Analysis (RCA)
What is an RCA?

- Safe, blame-free
- Multidisciplinary
- Focus on systems and processes
  - What happened?
  - Why did it happen?
  - What do we do to prevent it from happening again?
- Identify actions to prevent recurrence
- Often occur in context of systems-based M&M
What is an RCA?

- What happened?
- Why did it happen?
- What do we do to prevent it from happening again?

Goal: Quality improvement

(Improve our systems of care)
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors
- Avoid using unnecessary abbreviations
- Complete Incident Reports
- Attend a Root Cause Analysis (RCA)
- Practice High-Value Care
Practice High-Value Care

▪ Know your Board’s Choosing Wisely goals (www.choosingwisely.org)

▪ Avoid unnecessary lab testing

▪ Avoid unnecessary telemetry

▪ Discharge patients
  • Often the safest place for patients is not in the hospital

▪ Learn about the UCSF Center for High-Value Care
Resident and Fellow QI Incentive Program

- 3 all-program goals
  - Patient Experience
  - Patient Safety
  - Resource Utilization

- 26 program-specific goals
  - Designed by most residency and fellowship programs

- Opportunity to earn $1200
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors
- Avoid using unnecessary abbreviations
- Complete Incident Reports
- Attend a Root Cause Analysis (RCA)
- Practice High-Value Care
- Improve your handoffs
Handoffs are common

- If one team has 15 patients
- And that team gets handed off every morning
- And every evening
- For 28 days

\[15 \times 28 \times 2 = 840\]
Handoffs are linked to medical errors

- 59% of residents reported that one or more patients were harmed during their most recent rotation due to handoff problems
  - 12% reported that harm was major

- We overestimate how well our messages are understood
  - The most important information is NOT effectively communicated 60% of the time
  - (and not at all 40% of the time)

Kitch, 2008; Chang, 2010
Handoffs come in many shapes and sizes

- Cross Coverage
- Day and Night Teams
  - Shared responsibility
  - Workups in progress
- End of service
  - Shorter services
  - Location
- End of year
  - Ambulatory
Strategies to improve

Direct observations of handoffs at NASA, 2 Canadian nuclear power plants, a railroad dispatch center, and an ambulance dispatch center

- Standardize - use same order or template
- Update information
- Limit interruptions
- Face to face verbal update
  - with interactive questioning
- Structure
  - Read-back to ensure accuracy

Patterson, Int J Qual Health Care. 2004
Close the loop
UCSF Handoff Policy

- Patient summary (exam findings, laboratory data, any clinical changes);
- Assessment of illness severity;
- Active issues (including pending studies);
- Contingency plans (“If/then” statements);
- Synthesis of information (e.g. “read-back” by receiver to verify);
- Family contacts;
- Any changes in responsible attending physician; and
- An opportunity to ask questions and review historical information.
I-PASS is the UCSF approach

I  Illness Severity
   Stable, “Watcher,” Unstable

P  Patient Summary
   Summary statement; events leading up to admission; hospital course; assessment; plan

A  Action List
   To do list; timeline and ownership

S  Situation Awareness & Contingency Planning
   Know what’s going on; plan for what might happen

S  Synthesis by Receiver
   Receiver summarizes, asks questions; restates key action/to do items
I-PASS Fields formatted as EPiC sticky notes, with EPiC Problem List below Patient Summary
In this view, I can see the major I-PASS fields as column headings.
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors
- Avoid using unnecessary abbreviations
- Complete Incident Reports
- Attend a Root Cause Analysis (RCA)
- Practice High-Value Care
- Improve your handoffs
- If you see something, say something
IF YOU SEE SOMETHING, SAY SOMETHING.
BE SUSPICIOUS OF ANYTHING UNATTENDED.
Tell a cop, an MTA employee or call 1-888-NYC-SAFE.
What should I do if... (when...)

- Ask for help
- Tell your chief residents or program directors
- Report problems
  - Incident Reports, Near miss reports
  - Let us know: glenn.rosenbluth@ucsf.edu
- Participate in a Root Cause Analysis (RCA)

- GME Confidential Helpline: 415-502-9400

Additional info at: http://medschool.ucsf.edu/gme
7 simple things you can do to prevent errors and improve care

- Know the most common root cause of medical errors
- Complete Incident Reports
- Attend a Root Cause Analysis (RCA)
- Know your Department’s QI goals
- Improve your handoffs
- Avoid using unnecessary abbreviations
- If you see something, say something
In sum...

Residents are uniquely positioned to identify gaps in patient safety and quality of care.

Resident-level interventions can lead the way to improving patient care and safety.

- Residents and Fellows Council
- Quality and Safety Committees
- Resident and Fellow QI Incentive Program
“Take care of patients
Learn something
Have fun”

Dr. Charlie Bergstrom