# Do You Think Your Hospital is Providing Safe Patient Care?

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## The question may be phrased differently - Where does your hospital stand in terms of patient safety? Or what is the level of patient safety in your hospital?

These questions come up so frequently these days and we always assure ourselves that YES we do provide safe patient care! What is our degree of confidence when we provide such an affirmative answer? Paula Wilson, President of the Joint Commission International (JCI) identified three basic things that must change in hospitals to become safer or reach "zero harm":

1. A safety culture where healthcare professionals should become "mindful of all opportunities for failure of your systems and processes". Hospital staff should identify how things could go wrong and report possible mistakes or problems without fear of reprimand. They should understand that improving safety is their highest priority.
2. Process improvement is embedded in the day-to-day work and it is the concern of every individual around the hospital. It is crucial to have the front-line staff engaged in the development of systems and use of technology.
3. Leadership engagement at all levels which can be displayed through direct involvement and setting priorities. Hospital leaders should identify hazards and vulnerabilities that impact patient safety and then prioritize them to determine what action is required. They should adopt systems-based corrective actions; formulate sustainable improvements; and measure whether corrective actions were successful. (1)

But the question remains how can we assure ourselves that we are providing safe patient care?

## How Do We Measure Patient Safety?

In 2004, the Agency for Healthcare Research and Quality (AHRQ) devised a tool to conduct surveys to assess their patient safety culture in the hospital. The Hospital Survey on Patient Safety Culture, is a psychometrically tested survey instrument that helps hospital and unit leaders assess their patient safety culture and identify areas in need of improvement. Findings collected from hospitals that utilized this tool highlighted some areas of strength such as teamwork within hospital units. One area for improvement consistently came up as a result of the survey was thenon-punitive responses to errors and handoffs. (2)

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

The AHRQ Hospital Survey on Patient Safety Culture focuses on 11 dimensions:

1. Teamwork Within Units
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety
3. Organizational Learning - Continuous Improvement
4. Management Support for Patient Safety
5. Overall Perceptions of Patient Safety
6. Feedback & Communication About Error
7. Communication Openness
8. Frequency of Events Reported
9. Teamwork Across Units
10. Staffing
11. Handoffs & Transitions
12. Non-punitive Response to Errors

## The Patient Safety Indicators

Measuring patient harm rate has consistently been used as one of the patient safety indicators. Many hospitals track and analyze their total patient harm rate as a measure of patient safety. They report this information to the board through their quality and other medical staff committees. These occurrences include adverse drug events, catheter-associated urinary tract infections, central line-associated bloodstream infections, injuries from falls, obstetrical adverse events and early-elective deliveries, pressure ulcers, surgical-site infections, venous thromboembolism and ventilator-associated events.Tracking patient harm and identifying opportunities for improvement forces hospital leaders and board members to have conversations about big strategy issues to reduce harm.

The University of California San Francisco-Stanford Evidence-based Practice Center developed a set of Patient Safety Indicators (PSIs) after reviewing routinely collected administrative data including complications of anesthesia, foreign body left during procedure, Iatrogenic pneumothorax, post-operative pulmonary embolism or deep vein thrombosis, transfusion reaction, birth trauma–injury to neonate, etc. (3)
The main problem with such an approach is that it focuses on adverse events and carries with it a negative connotation. It is true that we should keep close monitor on such data but also we should spend equal time on assessing our patient safety baseline status and try to measure improvements on periodic basis. But in addition, we should look for some metrics on avoidable patient harm to guide our effortson preventing adverse events.

The National Quality Forum (NQF) has endorsed a number of healthcare performance measures addressing important areas of healthcare organizations. The most prominent work was presented in the document tilted: Prioritizing Measures -Multi-stakeholder Input on Priority Setting for Health Care Performance Measurement which highlighted the need to select the most pertinent measures. With our limited resources in risk management, healthcare professionals must prioritize their selection of measures and focus on the most effective approaches that will drive improvements in patient safety. (4)

## What Should We Focus On?

Obviously, most healthcare organizations are collecting information on actual adverse events and near-misses but fewer ones conduct systematic assessment of the factors leading to adverse outcomes and try to prevent them. Just like the risk assessment is considered the first step in the overall risk management function, also the assessment of safety culture and scoring of preventive measures is an important measure that will shape our patient safety approach. Hospitals should keep one eye on the assessment of patient safety factors and at the same time monitor patient harm.

## Suggested Checklist of Measures Leading to Patient Safety

If we want to ensure patient safety at our hospitals we have to conduct a comprehensive review our systems and processes. The following checklist consists of 50 questions can be used by healthcare professionals to check the degree of compliance with patient safety requirements and identify areas for improvement. The checklist was compiled by taking in account the Joint Commission International Accreditation Standards for Hospitals, 5th Edition. Simple calculation of the "YES" answers will determine the degree of your hospital vulnerability and will help you identify areas for patient safety improvement. (5)

## *References*

*1. Wilson, P, President of the Joint Commission International: "Future Is Now: The Era of Mobile Health", New York Health Forum, 21 May, 2015*
*2. Agency for Healthcare Research and Quality, Hospital Survey on Patient Safety Culture, AHRQ: http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/index.html*
*3. McDonald, K., University of California San Francisco-Stanford Evidence-based Practice Center: Measures of Patient Safety Based on Hospital Administrative Data - The Patient Safety Indicators, American Hospital Association, Health Research & Educational Trust, http://www.hhnmag.com/articles/3249-the-one-tool-you-need-to-measure-patient-safety-and-quality*
*4. Multi-stakeholder Input on Priority Setting for Health Care Performance Measurement-Getting to Measures That Matter, National Quality Forum, http://www.qualityforum.org/prioritizing_measures/*
*5. Joint Commission International Accreditation Standards for Hospitals, 5th Edition, April 2014*

**Checklist of MeasuresLeading to Patient Safety**
**Please check the most correct statement that reflects the actual practice at your hospital**

| No. | Are You Implementing the Following Measures? | YES | NO |
|---|---|---|---|
| 1 | Do you verify patients properly before blood transfusion, medication administration, or performing high risk procedures? | | |
| 2 | Do you use effective communication measures among members of the healthcare team? | | |
| 3 | Do you report critical test results in a timely manner? | | |
| 4 | Do you label high alert medications and limit access to the concentrated electrolytes? | | |
| 5 | Do you ensure correct-site, correct-procedure, correct-patient surgery through proper patient verification, site marking, and time-out? | | |
| 6 | Do you monitor and reduce the healthcare associated infections by performing proper hand hygiene? | | |
| 7 | Are you able to reduce the risk of patient harm resulting from falls? | | |
| 8 | Do you screen patients properly when they are admitted to the emergency room? | | |
| 9 | Have you established admission criteria to your critical care units? | | |
| 10 | Do you provide safe care during transfer of patients? | | |
| 11 | Do you provide discharge instructions to your patients? | | |
| 12 | Do you have a clinical summary on your outpatients? | | |
| 13 | Do you permit patients and families to participate in the care decisions? | | |
| 14 | Do you protect your vulnerable patients against physical harm? | | |
| 15 | Do you explain the high-risk procedures to patients / families when they sign informed consent? | | |
| 16 | Do you screen and assess your patients properly? | | |
| 17 | Do you have individualized initial assessments for special populations? | | |
| 18 | Do youmonitor the turn-around time of laboratory and radiology results? | | |
| 19 | Do you have a safe blood transfusion process? | | |
| 20 | Is there an individualized and integrated care plan for each patient? | | |
| 21 | Have you prepared individualized assessments and care plans for the following patients:<br>a) emergency patients<br>b) comatose patients<br>c) patients on life support<br>d) patients with a communicable diseases<br>e) immunosuppressed patients<br>f) patients receiving dialysis<br>g) patients in restraints<br>h) patients receiving chemotherapy<br>i) other vulnerable patient populations (frail elderly, dependent children, and patients at risk of abuse and/or neglect) | | |
| 22 | Do you provide efficient resuscitation services? | | |
| 23 | Do you have effective pain management? | | |
| 24 | Do you provide safe anesthesia and sedation services? | | |
| 25 | Do you have clear pre and post-operative care plans? | | |
| 26 | Do you have the required medications available when needed? | | |
| 27 | Do you have safe storage and dispensing of medications (unexpired)? | | |
| 28 | Have you identified individuals permitted to prescribe or order medications? | | |
| 29 | Do you dispense medications in the right dose to the right patient at the right time and monitor patients for adverse reactions? | | |
| 30 | Have you defined processes for identifying and managing sentinel and near-miss events? | | |
| 31 | Do you analyze undesirable trends and variations in the care processes? | | |
| 32 | Do you have a comprehensive program for prevention and control of infection? | | |
| 33 | Do you track infection risks, infection rates, and trends in health care-associated infections and adopt bundles to reduce those infections? | | |
| 34 | Do you have a process for managing expired supplies and the reuse of single-use devices? | | |
| 35 | Do you have proper disposal of waste? | | |
| 36 | Do you prevent infections associated with the operations of food services? | | |
| 37 | Do you protect your patients during demolition, construction, and renovation? | | |
| 38 | Do you follow proper isolation procedures to protect patients/ visitors? | | |
| 39 | Do you use personal protective equipment (gloves, masks, gowns, etc.) to prevent transmission of infections? | | |
| 40 | Do you monitor services provided through clinical or nonclinical contracts? | | |
| 41 | Do you use data and information on the safety of the supply chain for drugs, medical technology, and supplies to protect patients from contaminated, fake, and diverted products? | | |
| 42 | Do you implement clinical practice guidelines, protocols, or pathways to standardize care to patients? | | |
| 43 | Does the hospital leadership support a culture of safety program throughout the hospital? | | |
| 44 | Do you have guidelines to protect patients during clinical research? (if applicable) | | |
| 45 | Do you implement programs to monitor:<br>a) Safety and security<br>b) Hazardous materials<br>c) Emergency response to epidemics and disasters<br>d) Fire safety<br>e) Medical technology<br>f) Utility systems | | |
| 46 | Do you orient and continuously train your staff to ensure their competency in patient safety? | | |
| 47 | Do you implement proper credentialing of medical, nursing and other healthcare professionals? | | |
| 48 | Do you practice effective privileging of independent medical staff? | | |
| 49 | Do you have an ongoing evaluation of the professional practice of physicians? | | |
| 50 | Do you have proper management of patient information? | | |
| | **TOTAL** | | |

**Hospital level of vulnerability: Number of items answered “YES”**

| 0 - 12 | 13 - 25 | 26 - 38 | More than 39 |
|---|---|---|---|
| You are in serious trouble and you need to take another look at your operations | You need to take things more seriously and put active efforts to resolve the items answered as “NO” | You have established the infrastructure but you need to work harder to convert the “NO”s into “YES”s | You certainly have many good things in place and there is no reason why you cannot meet the remaining items |