DEVELOPING A ROBUST PATIENT SAFETY PROGRAM

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Disclosures

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Objectives

- Discuss a brief history of patient safety and its association with quality in health care
- List patient safety related initiatives in past twenty years
- Review regulatory elements elements of patient safety for transplant programs
- Examine the role of Morbidity and Mortality conference in patient safety
- Identify transplant specific patient safety initiatives

History of Patient Safety

- Resulted from individual ineptitude
- Presumed well trained/educated practitioners do not make errors
- Error = incompetence
- Punishment appropriate and effective
- Low reporting and learning from errors
History of Patient Safety

Harvard Medical Practice Study


IOM To Err is Human 1999

IOM Crossing the Quality Chasm 2001

Committee on Quality of Health Care in America

- Meta analysis
- Injuries to patients is pervasive
- Chronic threat to public health
- 44,000 to 98,000 patients die each year due to preventable medical errors
"You can’t make planes safer by asking pilots to please not crash”

Patient Safety and Quality

- Crossing the Quality Chasm
  - Multiple dimensions of U.S. health care system is flawed
- Classification of Quality Defects
Levels of Change

Level A
- The patient experience

Level B
- Functioning of small units of care delivery (microsystems)

Level C
- Functioning or organizations that house or support Microsystems

Level D
- Environment of policy, regulation, payment, accreditation

Knowledge Based
Patient Centered
Systems Minded

Level B: Changes in Microsystems of Care
10 Simple Rules Proposed

Rule 6

Current
- Do no harm
- Individual responsibility

Proposed
- Safety is a system property
- Systems designed to help mitigate errors

Six Aims for Improvement
Defining Patient Safety

- **IOM**
  - Prevention of harm to patients
    - System of care that prevents errors, learns from errors, and built on a culture of safety

- **AHRQ**
  - Adds “freedom from accidental or preventable injuries produced by medical care"
Joint Commission Patient Safety Goals

- Identify patients correctly
- Identify patient safety risks
- Improve staff communication
- Prevent mistakes in surgery
- Use medicines safely
- Prevent infection
- Use alarms safely

CMS CoP

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Transplant</th>
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<tbody>
<tr>
<td>Focus on high-risk, high-volume, problem-prone areas</td>
<td>Written policies</td>
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<tr>
<td>Must track</td>
<td>Adverse events during any phase of transplant</td>
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<tr>
<td>- Medical errors</td>
<td>Must address process for</td>
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<tr>
<td>- Adverse events</td>
<td>- Identification</td>
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<td>Implement preventative measures</td>
<td>- Reporting</td>
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<td>- Feedback</td>
<td>- Analysis</td>
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<td>- Learning</td>
<td>- Prevention</td>
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U.S. Department of Health and Human Services HRSA
Adverse Event Policy

- Adverse Event/Patient Safety Policy
  - Transplant specific
- Process used to
  - Identify
  - Report
  - Investigate
  - Prevent adverse events
- Types of Events
  - Non-transplant related events in transplant patient
  - Transplant specific events

Adverse Event Policy

- Timeframe for
  - Reporting
  - Investigation
  - Analysis
- Who is involved and roles
  - Who leads investigation, who participates
- Classification of events
- Methodology to investigate serious events
  - Root Cause Analysis
Adverse Event Policy

• Corrective action with timeframes and ownership
• Demonstrate how analysis of events are used in prevention
• Role & relationship of Morbidity & Mortality Conference
• Role & relationship of Risk Management

Event Reporting

• Events collated for all transplant patients
  • Transplant nursing units
  • Non transplant units
  • Outpatient
• EMR – tag all transplant patients
• Create identifier for Transplant in event reporting system
  • Create virtual location of ‘transplant’
  • ICD9/10 Codes
• Manual review by RM
Non-transplant Specific Events

Infection Rates

Medication Errors

Other AE’s

EBM’s

Falls

Transplant Engagement in Event Review

Step 1
- Event reviewed by Transplant Risk Manager (RM)

Step 2
- Thorough analysis conducted by RM and Nurse/Program Manager

Step 3
- Engage Transplant QA/Multidisciplinary Team as indicated for thorough analysis

Step 4
- Events trended and aggregate reported to Transplant QAPI
Transplant Engagement in Event Review

Step 1 • Event reviewed by Transplant Risk Manager

Step 2 • RCA Indicated

Step 3 • Engage Transplant QA/Multidisciplinary Team

Step 4 • CAP reported to Transplant QAPI

Step 5 • CAP reported to Hospital Patient Safety Council

Transplant Organization Chart

• Reflect integration of
  • Risk Management
  • Nurse Managers on transplant units
  • Transplant Pharmacists
  • Infection Control Coordinator

• Transplant QAPI Committees
  • Reflect participation

• Transplant Adverse Event Policy & Procedure
  • Describes personnel, roles, responsibilities and reporting
Events Reported

Increasing Identification & Reporting

- Perception of blame and reprimand pervasive among staff
- Constant education
  - Live classes
  - On Line assigned classes
- Reporting of data back to individual programs
- Critical to use data to make change
- Required ‘events’ to be reported in order to address issue
- Added patient safety and event reporting to JD’s
- Included in competencies for all staff
- Included in hospital and transplant specific orientation
**Event Surveillance**

- Safety goal is to reduce injury or harm
- Many medical errors often do not lead to harm
- Distinguish between error and harm
- IHI Global Trigger Tool
  - Focuses on ‘commission’ events – not ‘omission’ events
  - Include only categories of harm from risk stratification tool
  - Audit 20 medical records per two weeks
  - 30 mins per record
  - Dedicated reviewers – consistency
- Help to monitor effectiveness of improvement initiatives

**Morbidity & Mortality Case Conference**

- Traditional role in academic medical training
- Focus on professional learning
- Included in comprehensive patient safety and quality plan at many hospitals
- Transplant programs conduct ‘thorough analysis’ though the M&M process
Transplant M&M and Patient Safety

• Policy & Procedure
  • Define scope of M&M
• Clear communication and buy-in
• Structured review
  • System review
  • Multidisciplinary engagement
• Communication of cases to Multidisciplinary team in advance
• Participation of Quality (and Risk Management)
• Valuable advancement to MD training at all levels

Community Sharing/Learning

• Living donor deaths secondary to catastrophic hemorrhage
• Report of mortality and significant morbidity due to use of specific hemostatic clips
• Manufacturer issued contraindication warning against use in LD nephrectomy
• Three further LD deaths occurred where clips were used

Why were clips still in use following manufacturer warning?
Recall Procedures

- Know your hospital procedure
- Especially important for VAD programs

Living Donor Kidney Discarded
UNOS/OPTN Reportable Events

• Potential disease transmission
  • Infection
  • Cancer
  • Deceased donor
  • Living Donor

• PHS High Risk Donor
  • Includes screening of potential living donors
  • Post-transplant testing for disease transmission

• Deceased donor culture processing

• Vessel tracking and reporting

• Patient safety Contact
  • Back-up

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Living Donor Events

• Death of a living donor
• Native organ failure of a living donor
• Living donor organ recovered and not transplanted
• Living donor organ recovered and not transplanted to the intended recipient

• Aborted living donor surgery after induction
Safety Situation:
A voluntary and confidential system that provides members the opportunity to report situations or activities that could have affected patient safety. These situations may be related to patient safety, organ placement/availability, communications, clinical information accuracy, or risk of disease transmission that was prevented. Situations that may not directly impact safety, availability, or utilization but cause concern from a transplantation, donation and/or quality perspective may also be reported.
Conclusion

- Patient safety is the foundation of any quality improvement program
- Adverse event identification, reporting, analysis, and improvement
- Clarification needed of transplant role in non-transplant specific events
- External reporting of transplant specific events

Resources


Institute of Medicine, Crossing the Quality Chasm: A New Health System for the Twenty-first Century (Washington: National Academy Press, 2001).

http://www.organdonationalliance.org/educational-resources/transplant-toolbox/


