

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Risk management eliminated in wide-ranging program

Successful initiative sees reporting ranges jump 250% to 500%

A comprehensive safety initiative at Baylor Grapevine, a 104-bed not-for-profit facility in Grapevine, TX, has been characterized by a wide range of innovative strategies, not the least of which was the elimination of the risk management department.

“With a risk management approach, errors are seen as a person’s responsibility,” explains **Traci Atherton**, EN, BSN, vice president of clinical support. Instead, safety issues are identified through the “I Plant Flags” campaign. “It started as a reward program, but it turned out to be much, much more,” she says.

The program was one of several initiatives that resulted from Baylor Grapevine’s retention of The MEDSTAT Group of Ann Arbor, MI, in July 2000 to review its safety program, and specifically from results of the MEDSTAT Patient Safety Organizational Assessment Tool survey. **(For a detailed description of the MEDSTAT patient safety tool, see box, p. 3.)** “Before we started working with MEDSTAT, we already had looked at safety issues through our environment of care committee, and we already had a program in place,” notes Atherton. “What [the tool accomplished] was a heightening of awareness that we needed to enhance things we were doing; it helped us to recognize areas in which we could do a better job.”

The hospital must be doing something right: Baylor Grapevine reports an increase in reporting ranges from 250% to 500%. **(For more information on results produced by the Baylor Grapevine safety program, see box, p. 2.)**

The “I Plant Flags” program is a way to increase understanding and awareness of safety issues, and to encourage staff to be more proactive, Atherton explains.

“If you walk down the road and see a pothole, you sometimes put up a flag so that everyone who comes after you is warned,” she says. “Our potholes are safety issues. We hope that when somebody comes up to the ‘pothole,’ they don’t fall in. If we have a near miss, we ‘plant a flag.’”

How, exactly, are the flags planted? At about the same time Baylor Grapevine was working with MEDSTAT, it had become involved in a joint venture with Philadelphia-based Doctor Quality to develop a web-based error tracking system. “MEDSTAT recommended we implement the Doctor Quality system,” says Atherton.

The need for this system was further underscored through several needs assessment surveys, including one by MEDSTAT, one by the hospital board, and an employee survey. “We found in our staff survey that identifying patient incidents was too confusing under the old system,” she says. “Now, they go in and plug in answers. It has also eliminated separate forms for patients and visitors. Now, everything goes into the same system.”

Since errors are no longer a risk management issue, staff plant flags by entering their report into the system to inform their manager. “The manager then decides if this is a departmental issue. If so, they actually pull the appropriate team players together to fix the problem, go into the medical error tracking system, enter the information about the situation and the follow-up,” says Atherton.

As patient safety issues gain importance, American Health Consultants has created this supplement as a service to our readers, to provide up-to-date information on patient safety issues and trends, together with expert advice on how to meet the coming imperative for better quality and safety in patient care. Special thanks to Safety-Centered Solutions Inc. for help in preparing this issue.

“Through the medical error tracking system, they can stratify and post their own department-specific data. If it is an interdepartmental issue, it goes through our quality committee and then the request is issued for a team. Quality management will fill out an occurrence report.”

The new tracking system and the “I Plant Flags” buttons staff are wearing throughout the hospital have raised awareness significantly. “We now have everyone looking for issues before the patients and families see them,” Atherton observes. “People are asking, ‘What are these I Plant Flags buttons?’ It’s a great way to communicate as well as to educate, and more people are driving around the ‘potholes.’ It’s encouraged staff, patients, and physicians to ask more questions.”

Even if you’ve got a successful safety program under way, Baylor Grapevine’s experience demonstrates that it’s a good idea to have another pair of eyes take an objective look at what you’re doing, she says.

“MEDSTAT re-examined our policies and procedures and made sure safety was an integral part of that,” Atherton recalls. “[It] recommended the board survey, highlighting the importance of what we do in regard to communication with the board. [MEDSTAT] further commented on our policies and procedures, suggesting that we be sure to highlight high-risk issues that may be unique to certain diagnoses.

“[It] recommended the employee survey to identify our staff perception of safety concerns,

Success Factors in Error Reporting

- ✓ Leadership commitment
- ✓ Multidisciplinary support
- ✓ Education: Train the Trainer and integrated with ongoing training
- ✓ Communication: Newsletters, department meetings
- ✓ Incentives: Financial and nonfinancial
- ✓ Case studies, self-learning packets
- ✓ Open-book management
- ✓ Recognition of “reporters”
- ✓ Decentralized management: Nurse managers follow and are accountable for error tracking and resolution
- ✓ Feedback of data

Source: Baylor (TX) Health Care System.

Benefits, Outcomes of Baylor Grapevine Safety Program

1. **Benefit:** Reduced resources for data collection/analysis/management.
Outcome: \$25,000 to \$35,000 average annual savings in data collection (savings of 0.5 FTE to 0.75 FTE for a mid-sized community hospital.)
2. **Benefit:** Increased number of events reported.
Outcome: Increase in reporting ranges from 250% to 500%.
3. **Benefit:** Reduced time to track errors and make improvements.
Outcome: Reduced time of 25% to 50% for follow-up and resolution.
4. **Benefit:** Increased staff satisfaction with reporting.
Outcome: High staff satisfaction scores with ease of reporting (>4 on 5 point scale.)
5. **Benefit:** Increased satisfaction with analysis and follow-up.
Outcome: Increased satisfaction scores with managers (>4 on 5 point scale.)

Source: Baylor (TX) Health Care System.

and whether they believed we provided safe care.”

The MEDSTAT tool also identified opportunities for additional staff education. “For example, we realized we needed do a better job of communicating the fact that we had an ergonomics program,” says Atherton. “Our managers knew about it, but many of our staff did not.”

Working with MEDSTAT “definitely reinforced some of what we already knew, and highlighted some things we may not have thought about,” Atherton continues.

“The key was that it reinforced the need to develop a proactive risk management program and give it a more positive tone. Now that it’s seen more as a commitment to safety, people view it more positively. Also, MEDSTAT encouraged us to bring the patient into the problem-solving process,” she says.

“We were six months ahead of the Joint Commission Accreditation of Health Care Organization’s [new safety standards] because of MEDSTAT. We actually bring patients into the process and have them problem solve with us when we have a near miss or an incident. There were a lot of revisions in our falls program as a result of meeting with a family who had an occurrence with a fall.

That's the whole idea behind 'I Plant Flags.'"

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Patient safety tool focuses on best practices

The MEDSTAT Patient Safety Organizational Assessment Tool used so successfully by Baylor Grapevine in Grapevine, TX, was derived from the best information available through a number of resources, explains **Deborah Carpenter**, RN, MSN, director, Clinical Management Products Division, who works out of MEDSTAT's Washington, DC, office.

"We went through the literature and did an exhaustive review of the best practices and the conventional wisdom of providers and hospitals," she explains. "We organized them in a manner that we borrowed from Stephen Shortell, PhD, of Northwestern University." Shortell, she explains, posits four components for a successful safety program:

- **Strategic issues:** Is there executive leadership?
- **Structural issues:** Do you have the infrastructure to handle the program?
- **Cultural:** Is it safe to talk about errors in your work environment?
- **Technical:** Do you have training programs in place?

"We added a fifth component: medication," says Carpenter. "And patient safety experts also indicated that patient involvement needed to be included."

MEDSTAT provided Baylor Grapevine with on-site consultation services as part of the program. "Before we even looked at their policies and procedures, we reviewed meeting notes and minutes, talked to nurses, interviewed CEOs, and so on," she recalls. "Then we conducted a mock survey, much like one the Joint Commission [on Accreditation of Healthcare Organizations] would perform. Finally we provided a 30-page document indicating where we saw gaps in the program, which Baylor Grapevine then used as a road map for additional changes."

MEDSTAT has seen a growing demand for this

type of service since the Institute of Medicine report on medical errors, and sees the new tool as a logical extension of its services. "We have long been committed to providing QI activities, and we perceive patient safety as a spoke in that umbrella," Carpenter asserts. MEDSTAT's safety tool can be used by hospitals of all sizes, she adds. "There are 10-bed hospitals interested in it, and 'Big Baylor' is, as well. It's a good way to help you focus on your specific areas of need."

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An Inside Look at MEDSTAT Tool

The MEDSTAT Patient Safety Organizational Assessment Tool includes four major response categories:

- Not considering the practice
- Discussed the practice, but no action taken to put in place
- Practice approved, some action taken to put practice into place
- Considerable action taken to put practice into place

The following offers an outline of the survey breakdown, along with sample questions:

Section 1 — Strategic/Executive: "The organization has a written plan related to patient safety, which is reviewed by the board annually."

Section 2 — Structural: "There is a surgical checklist that addresses patient safety issues."

Section 3 — Cultural: "Credible root-cause analysis is done to determine system issues in adverse events and ways to prevent future process lapse."

Section 4 — Technical: "Surgery or other procedures are videotaped to observe interaction, identify areas for improvement, and demonstrate team dynamics."

Section 5 — Medication-Related Safety Practices: "Color-coded wristbands are provided for patients with allergies."

Section 6 — Patient Involvement: "At the time of medication delivery, the clinician discusses with the patient the name, purpose of the drug, effects of medication."

ER demand still rising, endangering patients

As emergency room (ER) demand continues to outstrip supply, serious threats to patient care are emerging, according to officials at the Washington, DC-based Center for Studying Health System Change (HSC). Just how serious the situation has become is outlined in a May 2001 HSC Issue Brief, *Emergency Room Diversions: A Symptom of Hospitals Under Stress*. Here are some of the stark realities reported by HSC:

- On average, two hospitals a day in Boston closed ERs to ambulances this year, sending patients to other facilities.
- The Cleveland Clinic reportedly was closed to ambulance patients an average of nearly 12 hours a day.
- Syracuse, NY, hospitals do not have the capacity to admit ER patients on an ongoing basis, so they regularly rotate times when they are closed to new patients.

HSC regularly conducts site visits to 12 nationally representative communities: Boston; Cleveland; Greenville, SC; Indianapolis; Lansing, MI; Little Rock, AR; Miami; Northern New Jersey; Orange County, CA; Phoenix; Seattle; and Syracuse, NY. Researchers interview leaders of local hospitals, health plans, physician organizations, and representatives of key employers and policy-makers.

In its report, HSC notes that closure and diversion programs have occurred more frequently in the past two years. That's not surprising; HSC cites these changes in hospital capacity between 1994 and 1999, according to the American Hospital Association:

- 8.1% decrease in ERs, from 4,547 to 4,177;
- 17.7% drop in medical/surgical beds, from 533,848 to 439,426;
- 2.8% drop in ICU beds, from 72,229 to 70,215;
- 3.4% drop in special care beds, from 15,373 to 14,848;
- 15.6% decrease in total inpatient beds, from 621,450 to 524,489.

"If someone has a very critical emergent condition and there are a number of [ERs] on diversion, it may take longer for that patient to be cared for. What's more, he or she may go to a facility that is not as well equipped to handle that particular problem," notes **Paul B. Ginsburg**, PhD, president of HSC. "The higher proportion of time some ERs

are blocked, the higher the probability someone is going to have a critical need and is not going to be able to be served properly."

What's more worrisome, notes Ginsburg, is that the relationship between the number of diversions and the increased threat to patient safety is not necessarily linear. "If the diversions double, the probability that care will be [negatively] impacted more than doubles. If you have three hospitals in a given community, and if one is occasionally on diversion status, that may not pose much additional risk, but if on occasion all three are on diversion status, you have more than three times the risk. In addition, as the medical problems become more severe, the increased risk becomes more significant."

Having an ER on diversion at specifically designated times of the year is probably an essential part of running an emergency system efficiently, Ginsburg adds, noting that a facility can't afford to have too much capacity simply standing around. "But there's a point at which you can go beyond what's reasonable, and it has gotten noticeably worse over the past two years."

Ginsburg says policy leaders must determine whether stopgap measures such as diverting ambulances and postponing elective surgeries are sufficient to meet the current challenge, or whether policy intervention is needed.

Ginsburg says he supports targeted financial subsidies for ERs. "The ER is probably not a big money maker, and perhaps even loses money in the case of uninsured patients. As health care becomes more competitive, some very targeted subsidies would probably be appropriate. After all, the ER provides standby capacity; since demand is erratic, it can never be used as efficiently as other departments in the hospital. Therefore, it should be seen as being in a different category."

Another solution, currently being employed in Boston, involves expanding ER and inpatient capacity. Massachusetts General and Brigham and Women's hospitals have reopened about 300 beds, including most of the beds closed in the mid-1990s to reduce operating costs.

Ginsburg offers this qualifier, however: "In Boston, there seems to be a significant shift in demand generally towards prestigious teaching hospitals, so they need the beds. In the past, they had to reduce capacity because so much was unused. Now we have a shift, where there are lots of unused beds and closures in the suburbs. So this could simply be a reflection of an increase in demand for their services." ■