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'Spread' remains challenge in patient safety improvement

The good news: Top performers show that errors can be eliminated

This March, the industry once again celebrated National Patient Safety Awareness Week — an apropos title as quality professionals have certainly become increasingly aware of the importance of patient safety in recent years. But how well have we done?

Experts interviewed by *HBQI* give the industry a mixed report card; top-performing hospitals have demonstrated that it's possible to reduce errors in specific areas to zero, but not all facilities are mirroring that level of achievement. Many facilities have achieved excellence on specific units, but have not yet carried that excellence hospitalwide.

"Our leadership in healthcare has been trained for years in command and control; we are very good at seeing a problem or a task, understanding it and fixing it, and when we're done, moving on to the next problem," says **Diane C. Pinakiewicz**, president of the Boston-based National Patient Safety Foundation, which instituted National Patient Safety Awareness Week. "That approach to performance improvement is what we do best. So, we see very well-proven, evidence-based processes, but what we do not see is spread and sustainability, because we approach problems the way we're used to approaching them. When you get to your solution to problem number five, your solution to number one potentially starts to unravel behind you."

Patient safety improvement, she continues, "abounds in pockets —

KEY POINTS

- Hospital quality professionals, staff must think more broadly.
- Map all the areas in your facility where patients would benefit from specific best practices.
- Recognize the potential danger in all medical procedures.

but it's not being spread and getting us in the aggregate where we want it to be."

Those variations occur between hospitals as well, adds **Leah Binder**, CEO of The Leapfrog Group. "We've achieved the highest standards in some hospitals, while others are frankly dangerous; there remains huge variation."

So, she continues, best practices have been identified in a number of areas. "What some have done with central-line infections is brilliant. Surgical checklists have been very successful. We know what works and how to do it, but what we can't figure out is how to get every hospital to do it," she says.

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EDITORIAL QUESTIONS

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"We hear a lot of people talk about central-line infections, and many will say they have done well in the ICU," adds **Carol R. Haraden**, PhD, vice president of the Cambridge, MA-based Institute for Healthcare Improvement. "But there's also pediatrics, oncology, dialysis. It's not an ICU change, but an all patients with central lines change," she notes.

She suggests that QI teams map the areas in their hospitals where every patient would benefit from a positive change in processes. "Do we have a prototype? Yes, in intensive care, but wherever you go in a hospital you should get the best practice. Variability is still the norm, and it's a huge problem," she says.

Binder agrees. "The fundamentals that work with a problem work across the board; best practices must be hard-wired through policies and leadership," she says, but adds that this has been difficult to implement.

Attitude adjustment required

Most experts agree that while awareness of the importance of patient safety has increased, many hospitals have not succeeded in creating true culture change.

"Safety has risen way up on the priority list as a strategic imperative; most everyone gets the essence of it," says Pinakiewicz. "The challenge is not raising awareness, but helping people understand how to prioritize and focus on it."

"Hospitals are not doing what they should be doing to avoid errors," Binder adds. "Take the example of hand hygiene. Has a policy been passed by the board? Are there education programs? Do staff members do what every American you stop on the street says would be easy?"

She says that in a recent Leapfrog survey 70% of its reporting hospitals had appropriate policies in place. "But these hospitals tend to do better," she observes. "That's a nice majority, but what about the 30% that don't? Not to put in place the most basic, fundamental prevention hand-hygiene practices we know? That's very disturbing."

"Hand-washing is a challenge because we've chosen it to be," adds Haraden. "Right now there is a bacteriostatic curtain material available, but hospitals have decided it's too expensive and will not use it. We go the cheap way, relying on posters, which you become habituated to in a week and a half. The two things we rely on most are admonition and hard work — as if they would

work; they are the two weakest approaches. You can keep after people, but in a very busy environment, errors will happen." She says a "continual feedback loop" is needed. "You almost have to film someone, show it to them, and say, 'Here are four opportunities you missed today,'" she offers.

Haraden also sees the need for an attitude adjustment. "We fail to see all harm as preventable," she says. "We know there are some things where patients are harmed as a natural by-product of care, but if we define it as inevitable, we will lose curiosity. Sure, there is some irreducible number of errors, but we are nowhere close to it. We can reduce errors so much further than we have."

"The biggest challenge is changing peoples' attitudes towards safety," says **John Combes**, MD, senior vice president of the American Hospital Association. "In healthcare, on a one-to-one basis we underestimate the danger of what we do, and we have to change that attitude — everything we do comes with extreme risk. In order to do that we must be mindful, open to all sorts of input, rely on standard operating procedure when things go well and when they don't, rely on the ability to contain risk through teamwork, and allow ourselves to be directed by the members of the team that have the most information."

It can be done

Combes points to the latest findings of the Comprehensive Unit-based Safety Program (CUSP) as an example of changing attitudes as a key ingredient in achieving patient safety improvement. "The program developed by Peter Pronovost addresses a lot of change that has to come not only to technology, but adaptive changes — behavioral, cultural — to take up and implementation," he explains. "CUSP in the unit addresses cultural change, participating in teamwork and communicating — developing mutual accountability. CUSP takes a cultural approach at a unit level to adapt intervention — in this case the central-line bundle — in a certain way, such as insertion only when necessary, being fully gowned, and so on. Some call this a checklist — but to get it to work you have to get people to do it."

In this case, they clearly seem to have done that. With more than 1,000 hospitals in 48 states participating, representing about 2,000 units, "Initial data has shown a reduction of the central-line infection rate of about 80%," says Combes. "That mirrors the recent CDC report."

"The report from the CDC shows they fell 58% — from 43,000 in 2001 to 18,000 in 2009," notes Binder. "That's impressive, and a good number of hospitals was at zero or close to zero; that's exciting in the progress of patient safety."

Combes cites another critical aspect of CUSP: "It also measures changes in patient safety culture; it's really comprehensive," he says. *(For more information on CUSP, go to: http://www.onthecuspstophai.org/Abou-7631.html.)*

Culture change has long been recognized as one of the most challenging undertakings in patient safety improvement. What does Combes consider the keys to success? "Leadership engagement and support from the top are absolutely critical," he asserts. "For it all to work, is has to be supported by senior managers of the organization, and considered a priority. Progress has to be held up in front of the whole organization as an important way to change."

Pinakiewicz agrees. "What it gets back to is, the culture is the context — become what you are and practice it," she says. "It's not good enough to find a solution; someone has to make you understand you are completely accountable for the care you deliver."

For example, she continues, people talk a lot about accountability for clinical outcomes. "However, if you look at hospital bylaws, you see they oversee practice and deal with outliers, but what they do *not* deal with is accountability for behavior," she says. "You can have a disruptive doctor who's a large revenue generator, and as long as the outcomes are good do nothing about their behavior."

However, she says, "We understand now that this is a huge issue. If you have a doctor who disrespects another member of the team, or is not receptive to the fact there may be something to look at because they feel they are completely in charge, then you have people who are uncomfortable about speaking out; you have a subculture that does not allow for the practice of safe care. We now understand that can't be accepted, and leadership needs to be [intolerant] of that type of stuff. It gets back to accountability."

What is required, she says, is having "all people look at the process together and feel comfortable speaking up when part of the process is working in a way you are not comfortable about it being safe."

Combes agrees that engagement of physicians is a critical component of culture change. "They

have to be seen as a critical part of the team," says Combes. "And their partners — nurses and other staff — have to be included in accountability. If you learn to act as a team there is no problem being challenged when you are not following a checklist, not gowning completely or not using the right scrub."

Learn to prioritize

Pinakiewicz notes that with so many proven success stories, "People are overwhelmed by what they should do next and where to focus next. They have resource constraints that are worsening."

So how do you prioritize? "It depends on the individual organizational infrastructure, and what resources you have," she says. "But there are certain things you can do that cost nothing — ensuring you practice transparency, open disclosure to patients, and recognize that as a provider organization you're a guest in the life of the patient and do not have the right to withhold any information."

There are way too many errors that occur because providers choose to ignore the patient or family member, she asserts. "When you have a parent sit there and say there's something wrong with the child, the doctor may not listen because they think the parent is being emotional, not clinical. But who knows child better?" she says.

Finally, Pinakiewicz sums up her approach to improving patient safety with the following: "The work of patient safety is really not something that should be a project; it should be the way you do your work."

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Study: Palliative care cuts hospitalization costs

Quality of life improved as well, study says

A study published recently in *Health Affairs* shows that hospitalization costs for patients with certain terminal or serious chronic illnesses are significantly lower when palliative care is provided. In fact, the study of four hospitals in New York State showed an average cost of admission that was $6,900 lower for these patients.[1] Compared to another group of patients who received more traditional care, they were less likely to die in the ICU, did not spend as much time in intensive care, and were more likely to receive hospice referrals. The authors also asserted that the state's Medicaid program could save between $84 million and $252 million annually if every hospital in the state that had at least 150 beds implemented a palliative care program.[2]

"We based our selection criteria on patients typically cared for by palliative teams as described in the literature," notes lead author **R. Sean Morrison**, MD, director, National Palliative Care Research Center, Hermann Merkin Professor of Palliative Care, Professor of Geriatrics and Medicine, and vice-chair for Research in the Brookdale Department of Geriatrics and Palliative Medicine at Mount Sinai School of Medicine in New York City. "We looked at advanced cancer; cancer that had spread beyond the primary organ; patients with advanced heart and lung disease who had had one or more hospitalization; patients living with AIDS with one or more complication of the disease; and patients who had spent a long period of time in the ICU."

How could such saving be possible simply with the use of palliative care? "The key is that the palliative care teams identify patient values and goals for their care and selectively match treatment to those goals," says Morrison. "When you look at the [Medicaid] population, it involves 5%-10% of

KEY POINTS

- Patients spend less time in ICU and have lower in-hospital mortality rates.
- Identifying patient values and goals for their care is of primary importance.
- Palliative care improves quality of life.

the most complex, seriously ill patients. Hospitals are not designed to take care of them well; they're designed to care for the average person."

This, he points out, is a complete mismatch. "What palliative care teams do is align the mismatch; we make the hospital a better environment for the patient."

When you do a cost-benefit analysis of such a program, he continues, the choice becomes even clearer. "For the average 300-bed hospital, the program would include a physician, a nurse practitioner, a social worker, a chaplain, and typically some administrative support," he says. "That typically runs about $750,000 a year, while the average savings to a hospital range between $4 million and $5 million a year."

Palliative care teams, he adds, are in place in about 80% of mid-sized and large hospitals, and in 60% of hospitals overall.

Improving quality of life

Morrison notes that even when financial considerations are not factored in, palliative care offers significant benefits. "They focus on improving quality of life for patients living with serious or life-threatening illnesses," he says. "They address pain, so the patients feel better; they provide intensive communication about goals with the patient and family; and they help them navigate a complex health system."

In some sets of patients, he continues, palliative care has been shown to prolong survival — especially when connected with curative treatments. "It's very important it be done at the same time as life-prolonging or curative treatment," he says. "There are some patients who may live a long time with serious illness."

Morrison says he had already demonstrated the benefits of palliative care for non-Medicaid patients. "We did that study two years ago; we looked at five hospitals throughout the U.S., predominantly Medicare patients. The savings were even greater."[3]

This makes sense, he says. "When you look at Medicare and private pay, those patients are much more likely to have a primary care physician who can oversee their care; Medicaid patients often fall through the cracks," he explains.

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Tech helps facility slash HAIs by 22%

Staff demonstrate 'team spirit' for initiative

Princeton Baptist Medical Center in Birmingham, AL, was recently chosen as one of two national HIMSS/ASQ Stories of Success for the 22% reduction in healthcare-associated infections (HAIs) resulting from their adoption of a radio frequency identification (RFID)-based hand-hygiene monitoring system.

Applying the new technology was part of an ongoing effort to reduce infections, notes **Gloria Deitz**, RN, nurse manager for the post-op surgical unit, where the system was piloted. "We were monitoring our UTI's (urinary tract infection), our respiratory infections, and had some initiatives going along those lines involving assessment, and some initiatives on our processes and how to collect specimens," she says.

KEY POINTS

- Technology alone will not solve patient safety problems.
- Make sure staff knows you are seeking team success, not serving as a watchdog.
- Involve staff in new initiatives early on to ensure buy-in.

The new technology, provided by Proventix, began installation in February 2010. It's difficult to measure the actual improvement in hand-washing compliance that was achieved, says Deitz, because prior to that, "We had to do it manually using spot audits, so you're not really comparing apples to apples."

When the system was installed, the hospital had monitors placed in every patient room and in the hallways. The monitors were mounted along with hand-washing solution dispensers. Staff members were given tags, so the system could detect who was entering the room and whether they were washing their hands. "It also knows when you leave, and how many times you have used the system," Dietz adds.

In the first month, there were about 3,000 hand-hygiene attempts, she continues. "By December, the attempts had increased to over 45,000."

Staff buys in

Deitz says her approach with staff was not intrusive. "We explained the tags, and what the system would do, but stressed we were not installing a 'watchdog' system," she shares. "The staff just bought into it. As they saw their attempts go up, we saw our infection rate go down."

One of the key factors in this success, says Deitz, was providing the staff with frequent feedback on where they were compared to the previous year. The main vehicle was monthly unit meetings; in addition, she says, the vendor worked with infection control nurses and provided feedback on the progress that was being made. "The nurses wanted to know how they were doing, and as they saw the numbers going up it reinforced the importance of hand hygiene," Deitz explains.

She says that so far she has not had to single out individuals who were non-compliant. "Once they see the reports and they know, 'Hey, that's me,' it's like a competition," she explains. "Right now we do it as a group effort. We can pull up the individual if we need to or want to, but the attitude is 'We're working together to reduce infections, and this is what we need to do.' If I noticed that someone was not ever washing, I'd go to them and say 'I don't see you doing this,' and that would be all it would take."

Going beyond technology

Deitz notes that technology in and of itself will not accomplish quality improvement goals. "One of the keys is to let the nurses know how many infections you have on your unit," she says. "We even drill down to what we think is the cause and what you can do to prevent it from happening again. So, for example, we examine processes, techniques, and environmental conditions."

If you are considering adopting a hand hygiene monitoring system, she continues, "Involve the staff by letting them be in on the front end from the start. Let them know what you want to do and why. Also, explain that this is not a punitive move, but something designed to improve patient care and give quality care to patients. All nurses believe that to the core; they want to give the best possible care. This system is just a piece of technology that can help you with the process."

[Editor's note: For more information on hand washing monitoring systems, contact: www.proventix.com, www.handgienecorp.com, or www.hygienaUSA.com. Gloria Deitz can be reached at (205) 783-7653.] ■

Posted wait times an added advantage?

Impact on load-balancing to be studied by system

Given that patients are keenly interested in wait times, an increasing number of EDs across the country are taking advantage of new media to make this information more accessible to the public.

For example, many EDs enable consumers to access wait times online or via text on their cell phones along with a promise that patients will be seen quickly. When done well, such a strategy can boost volume, as well as patient satisfaction, but for health-care systems that operate multiple EDs in a given metro area, it also offers the potential advantage of directing patients to the least busy EDs so that bottlenecks are avoided and patient flow is evened out across the system.

With six adult EDs and one pediatric ED operating in the same region, Memphis, TN-based Methodist Le Bonheur Healthcare is uniquely situated to reap some gains in efficiency from the posting of ED wait times, which the health system began doing in August of 2010, explains **David**

Cummings, RN, CEN, corporate administrator, patient care operations, at Methodist Le Bonheur Healthcare.

"That is why we are looking at our arrivals by zip code to see if there is some load balancing of non-acute patients," says Cummings. "Our EDs are very strategically located in different quadrants of the city, so one of the things we are looking at is to see if there is a shift. People from one zip code might go to a different hospital based on wait times. There is nothing out there really published on this, so we will probably do a case study about our experience. We are trying to look at it fairly scientifically."

In addition to mapping arrival by zip code, Cummings says the hospital will also be tracking market share by payer mix to see if the posted wait times are linked to any changes.

While the impact on load balancing has yet to be determined, one result is already clear: Since the hospital began posting ED wait times at all of its adult hospitals, volume is up by 6% to 10%, says Cummings. Despite the increases, the leave-without-being-seen (LWBS) rate ranges from just 1% to 2.1%. "We have very good processes in place and good throughout upstairs, so we have the capacity to see more patients in an efficient way," adds Cummings.

Get your house in order

It is clear that posting ED wait times can be a good way to win business, but it is important to have your house in order first, emphasizes **Marty Carr**, MD, the medical director for the health system's emergency departments. "A couple of years ago, we undertook a project to make all of our EDs more efficient, and to get people in and out faster," he says, noting that the initial goal was to get people seen by a provider within 30 minutes of arrival. "Everybody thought that was pretty insane at first, but we time stamp everything [through our EMR], and we can follow the process and see where problems are. We did that, and times started to come down."

With such improvements in place, it was a not big deal to the clinical staff to post the wait times online. "It doesn't change our wait times. It just makes them more available to the public," stresses Carr. "We were already good, and this just shows what we do."

At press time, two of the health system's EDs were offering guarantees that patients would be seen by a provider within 30 minutes of arrival, and the remaining EDs were expected to offer similar guarantees shortly, according to Cummings. However, he says the health system has no plans to post the wait times for its pediatric ED, which is part of the health system's children's hospital.

"We chose not to post our children's ED wait times because we didn't want people to be confused and maybe go to another ED when they really needed to go to the children's center, even if the wait time is a little bit longer," says Cummings. "We take care of kids at all of our EDs, but we really want our kids to go to our designated pediatric, level one trauma center hospital."

Fortunately, since the EDs at Methodist Le Bonheur had already transitioned to an electronic medical record (EMR) by the time the posting of ED wait times was even discussed, there was no need for additional IT investments, explains Cummings. The health system uses an EMR platform developed by Kansas City, MO-based Cerner Corporation, and Cummings had already worked with the health system's IT group to put mechanisms in place to regularly retrieve key performance measures from the EMR.

"Within the Cerner platform, we created a real-time dashboard for people on the front line to proactively manage the ED, and that development gave us the ability to publish the [ED wait time] data," says Cummings. "We had the ability to do this, and it happens automatically. The data get [refreshed] every two minutes."

Differing definitions a marketing challenge

Posting ED wait times makes sense from a marketing standpoint, to be sure, but Cummings stresses that the practice is also in line with the health system's mission and philosophy.

"Our organization is very big about transparency in our quality measures and quality metrics. We post many of our quality measures online already, so to try and continue that transparency … we wanted to let the community know what they could expect from our EDs," adds Cummings, noting that many people assume that when they go to the ED, they are going to have to sit and wait. "We wanted to help dispel that myth, at least in our EDs, where our patients are seen by a provider in a room. They're not just sitting out in a waiting room."

In fact, one of the marketing challenges that Methodist Le Bonheur has run into is that now one competing health system is posting an ED wait time as well, but it is posting the wait time until a

patient is placed in a bed as opposed to the time until a patient is seen by a physician, nurse practitioner, or physician assistant — the standard used by Methodist Le Bonheur, explains Cummings. "Patients aren't [in the ED] to get into a bed. They are there to see a provider, but I think [the competing hospital] saw the value of posting ED wait times, and they are responding to our campaign for a reason," he says.

The concern, says Cummings, is that patients may not discern the difference in the two standards being used to describe wait times. "They are not measuring the same thing that we are measuring, and the public probably doesn't know the difference," he acknowledges. "What we are publishing is the average door-to-provider time over the previous hour, but there are lots of ways you can play with the numbers." ■

Guidelines offer models for improving quality

Revision could be springboard to better processes

Hospital ethics boards now can refer to national guidelines when developing procedural standards and processes for evaluating quality of ethics consultations (EC) and institutional EC processes.

The revised "Core Competencies for Health Care Ethics Consultation" contain these and other new sections relating to health care ethics consultations. The original core competencies guidelines, introduced in 1998, and the 2011 revised version are published by the American Society for Bioethics and Humanities (ASBH) in Glenview, IL.

"These guidelines are one of the most effective and cited documents ever published in the field of ethics consultation in the world," says **Andrea Frolic**, PhD, a clinical and organizational ethicist at Hamilton Health Science of McMaster University Medical Center in Hamilton, Ontario, Canada. Frolic is on the core competencies task force for the second edition of the guidelines.

Frolic has used the revised core competencies guidelines as they were evolving to recruit and train a team of health professionals who desired specific expertise in ethics consultation. "I also used that document for a performance evaluation of their skills, knowledge, and attributes as consultants," Frolic says. "I've found it a guiding light throughout the recruitment period and training process."

The hope of members of the core competencies task force is that the guidelines will serve as a go-to resource for people who are doing ethics consultations in hospitals, says **Anita J. Tarzian**, PhD, RN, associate professor, family & community health, University of Maryland School of Nursing, and program coordinator for the Maryland Health Care Ethics Committee Network, Law & Health Care Program, University of Maryland School of Law, all in Baltimore, MD. Tarzian chairs the core competencies task force for the second edition. "We are looking at strategies for getting the guidelines into the hands of people on ethics committees and who are doing ethics consultations," she says. "When it first came out in 1998, it was seen as a core resource for people on ethics committees. At that time, there was a focus on voluntary standards and a fear that you would usurp the health care providers doing this as part of their job. Since then, we've learned you can't have a handle on medical ethics if you don't include the clinical piece."

Healthcare decision-making and ethics consultations have reached a level of complexity that calls for standardization and a way to assess and ensure quality and competency, Tarzian notes. "It's time to take ethics consultation to another level, focusing on the standards of the service as opposed to the competency of the individual consultant," she says.

The revised guidelines carry this philosophy forward with a new focus on procedures and measuring or evaluating quality and effectiveness, Tarzian says. The guidelines hold institutions accountable for having some process for measuring the quality of their ethics consultant service, Frolic says. "A lot of academic medical centers already do this," she adds. "For those folks who have a more informally structured service, this will challenge them to really enhance their program. It's a radical concept, and I'm excited about that."

While some ethicists might take issue with the idea of measuring quality and efficiency in this realm, there are some practical reasons why it's necessary, Tarzian notes. Ethics consultants are responsive to timelines, for example. "To take a month to ponder whether or not it's OK to allow a family to keep a brain-dead pregnant woman alive on a ventilator so they could keep the baby is not helpful," Tarzian says. "Also, if you have 30 people involved in formal ethics committee meet-

ings, and you don't need 30 people, then you are taking up their time and should figure out how to provide a quality service that makes good use of your institution's resources."

One model for assessing quality that is cited in the revised guidelines is the Department of Veterans Affairs' Integrated Ethics model from the National Center for Ethics in Health Care. It's a comprehensive approach that is implemented throughout the VA health care system's 153 hospitals, says **Ellen Fox**, MD, chief ethics in health care officer with the Department of Veterans Affairs (VA) in Washington, DC. Fox is on the core competencies update task force. "Much has been written about the need for ethics consultation services to establish clear standards and metrics, but there has not been a great deal of progress," Fox says. "So in our system we were really responding to that need."

The guidelines task force looked for models, approaches, standards, and tools to reference and use in the revised document. Repeatedly, they returned to the VA's integrated ethics approach, Fox notes.

"The guidelines are very closely related to the integrated ethics model, and the tools are heavily referenced," she adds.

The VA also has a web-based program called ECWeb, short for ethics consultation web, that enables an ethics consultant to document consults and generate notes that can be catalogued electronically and, often, placed in the patient's record.

"It improves ethics consultation practices by tracking, trending, and documenting the critical steps taken throughout the documentation process," Fox says.

Revision addresses organizational ethics

Members of hospital ethics committees could expand their role if they embraced organizational ethics, which is another area highlighted in the revised guidelines, says **Mary V. Rorty**, PhD, MA, an adjunct clinical associate professor in the Center for Biomedical Ethics at Stanford (CA) University. Rorty also is on the guidelines task force.

Clinical, organizational, and ethical ethics all are part of a broader and more inclusive term called health care ethics, according to the guidelines.

"There are broader ethical concerns that don't have to do with didactic bedside clinical consultation but have to do with the ethical issues associated with quality in hospitals and concern for the ethical climate in their institutions," Rorty says.

The task force deliberately chose not to distinguish between subspecialties such as clinical ethics, organizational ethics, and professional ethics, opting instead to use the broader and more inclusive term health care ethics, the guidelines state. The guidelines gave examples of overlaps in ethics subspecialties, including these two:

- "Hospital purchasing offices choosing the least expensive sterile supplies, although their reliability in care is poor (business, organizational, and clinical ethics)."
- "Hospitals opening a new, revenue-generating service with resources that clinical staff would prefer to invest in improvements in an existing service (business, clinical, organizational, and professional ethics)."

The revised guidelines also are notable for what has remained the same in the 13 years since they first were published, Frolic says. "Most of the tables on knowledge and skills were only changed very minimally," she says. "That speaks to the staying power of the work that was done in the 1990s. They got a lot right in basic skills and competencies." ■

Learn the key items in new guidelines

Focus is on quality, measurement

The revised "Core Competencies for Health Care Ethics Consultation," by the American Society for Bioethics and Humanities (ASBH) contains new sections and tables addressing procedural standards and quality assessment.

"The report looks at what is the minimum infrastructure of an ethics consultation," says **Anita J. Tarzian**, PhD, RN, associate professor, family & community health, University of Maryland School of Nursing, and program coordinator for the Maryland Health Care Ethics Committee Network, Law & Health Care Program, University of Maryland School of Law, all in Baltimore, MD. "The initial core competencies report focused on what individual ethics consultants need. This revised document

recognizes there needs to be an infrastructure and institutional support."

Hospitals need a policy that defines who can request ethics consultations, how these are handled, and how to evaluate them, Tarzian says.

Here are some of the new features of the core competencies guidelines:

• Establish a framework for clinical and organizational ethics consultation.

Andrea Frolic, PhD, a clinical and organizational ethicist at Hamilton Health Science of McMaster University Medical Center in Hamilton, Ontario, Canada, says, "What I like about this new version is they include both clinical and organizational ethics consultation. The skills often are overlapping, and we see them as related rather than distinctive practices."

The revised guidelines expand the traditional scope of ethics consultants from being patient-specific to recognizing they might be consulted about business ethics issues, policy ethics issues, and other issues in the organizational realm, Frolic says.

"I like how this document addresses the broader practice and has a much more inclusive definition of the role of an ethics consultant, and it mirrors a lot of people's actual practice, which I think is helpful," she says.

• Address HCEC evaluation and quality improvement practices.

The report evaluates consults in terms of ethics services, says **Mary V. Rorty**, PhD, MA, an adjunct clinical associate professor at Stanford (CA) University. "It's more about whether you have a machine that could do the job that the outcome of the job that's done," Rorty explains.

The guidelines include a table that divides the category of evaluating quality into three sections, related to structure, process, and outcomes. Examples of the recommendations under each of these sections are as follows:

— Structure. "Identify root causes, underlying structural gaps (e.g., staff shortages, historical precedent, lack of funds for continuing education)."

— Process. "Identify major root causes underlying process gaps (e.g., lack clear policy standards, resistance to change, unable to formulate ethics question, competing demands on staff time)."

— Outcomes. "Identify major root causes underlying any satisfaction gap (e.g., misunderstanding of the consultation process, lack of timeliness, role confusion)."

Members of ethics committees could evaluate their programs by collecting data on the types of ethics consults referred to the committee and break these down by department, Tarzian suggests. "They could see that we're getting a lot of consult requests on when you can stop the ventilator in patients with X syndrome, so maybe we need to develop an educational intervention to help staff with this," she says. ■

Patient safety and metrics: Obtain good data

Risk managers are collecting data and using metrics in many ways lately, and patient safety should be a primary focus, says **David G. Danielson**, JD, CPA, senior vice president of clinical risk management at Sanford Health in Sioux Falls, SD.

Patient safety can be improved by the use of metrics, but that improvement first depends on having good data, Danielson says. He recommends, at a minimum, that providers collect data related to the National Quality Forum's Safe Practices for Better Healthcare -- 2010 Update. *(The safe practices guide is available at www.qualityforum.org/About_NQF/CSAC/Safe_Practices_Table.aspx.)*

"Tracking and trending will help a system identify potential problems. From there, solutions can be developed," Danielson says. "The key is the implementation of the solutions. An organization must have both the awareness and the capability to make solutions stick. This is heavy work, as the inertia of the status quo fights against the changes."

Metrics can help isolate the problems, making it possible to correct them and improve patient safety, Danielson says. "We regularly hold multicausal analysis forums to look for ways we can improve our clinical practice," he says. "I use the data to change policies and procedures, talk with clinical departments and providers, and report to senior management about improving safety for our staff and patients."

Danielson and his colleagues did just that with a medication reconciliation project. The pharmacy was able to gather data about the types and locations of drug variances, and that information was presented to senior management. The senior man-

agers authorized an education program about the importance of making sure there was a correct listing of each patient's medications. "Using the data, we focused on both the higher risk areas as well as those areas with higher variances," he says. "After the education, we again tracked and trended the variances and we have improved."

Useful information can be obtained by performing a root cause analysis or failure mode analysis when an adverse event occurs, to find out what went on behind the event, says **Alan Rosenstein**, MD, MBA, medical director of Physician Wellness Services, a company in Minneapolis that provides services to troubled physicians and their employers. "The analysis often finds that there were failures in communication and/or collaboration," he says.

Rosenstein notes that, according to The Joint Commission, 65% of sentinel events can be traced back to an error in communication. When performing post-event analysis, risk managers need to evaluate the contribution of human factor issues as well as structural process issues. Then the risk manager should look for solutions that will address communication gaps to prevent an unwanted reoccurrence of a potentially preventable adverse event, he says.

"Additionally, it is important to implement standard patient safety and quality indicators in each department or area with measurements specific to each department or area," Rosenstein says.

An indirect measure of patient safety and quality is patient satisfaction, Rosenstein notes, which can be determined through surveys. In such a survey, include questions that address the patient's comfort and the ability to interact with providers and obtain the information they thought was necessary to understand their situation and make the right decisions, he says. Research has shown that poor patient satisfaction correlates with higher medical malpractice risk, he says.

These surveys also can be extended to an organization's staff to determine safety culture and staff satisfaction, he suggests. "These surveys should include questions based around specific behaviors and perceptions around communication and collaboration," Rosenstein says. "Poor communication and collaboration are strongly linked to adverse events and outcomes." One example of a survey question that can help evaluate the safety culture is "How would you rate the effectiveness of physician communication/ nurse communication in helping you understand your medical condition?"

Change sometimes can best be achieved by addressing the "human factor" issues at the individual level through education for all staff members to encourage and facilitate better communication and improved collaboration between team members, he says.

"The education should raise the level of awareness of what disruptive and unprofessional behaviors are and how they can negatively impact work relationships, communication flow, and team collaboration, and how they can adversely impact outcomes of patient care," Rosenstein says. "Stress the importance of holding individuals accountable for their actions. Provide workshops on improving communication skills. Stress the importance of timely intervention, coaching, and counseling, and if needed, more comprehensive interventions."

Coaching also helps individuals understand what they are doing to impede patient safety and also helps improve staff member performance. Examples would be helping individuals see how their behaviors might be perceived by others (raising emotional intelligence), and providing tools and techniques that will help them deal appropriately with factors affecting their behaviors. Additionally, an intervention might be necessary for individuals who are non-compliant or whose actions pose an immediate risk to patient safety, he says.

Rosenstein's company once helped coach a physician who was perceived as "hotheaded" and "unapproachable" by his physician peers. He described himself as passionate and committed and was resistant to change. He failed to see how his "message" was consistently misinterpreted or lost totally due to his delivery of the message, Rosenstein says.

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Through coaching he was able to increase his awareness of how his delivery of messages was destructive vs. constructive, recognize how to better manage the day-to-day stress and frustration inherent in clinic practices, and more selectively choose the issues he felt strongest about. He realized he had been regularly asked to "carry the flag" on behalf of his colleagues he were unwilling to bring the issue forward, which he stopped doing.

The coaching helped the physician engage in a process of consciously identifying "new behavior" vs "old behavior" and intentional efforts to gravitate toward "new behaviors."

"In any of these instances, having hard data through capturing these metrics will create a much more compelling case for change," he says. ■

AHRQ releases results of safety culture survey

The Agency for Healthcare Research and Quality's Hospital Survey on Patient Safety Culture 2011 User Comparative Database Report has released results based on data from 472,397 respondents in 1,032 hospitals.

In its executive summary, AHRQ emphasizes that "hospitals do not necessarily administer the hospital patient safety culture survey every year. They may administer it on an 18-month, 24-month, or other cycle. Therefore, the comparative database is a 'rolling' indicator."

According to AHRQ, the survey covers twelve components of patient safety culture:

- communication openness;
- feedback and communication about error;
- frequency of events reported;
- handoffs and transitions;
- management support for patient safety;
- nonpunitive response to error;
- organizational learning – continuous improvement;
- overall perceptions of patient safety;
- staffing;
- supervisor/manager expectations and actions promoting safety;
- teamwork across units;
- teamwork within units.

Results will be released annually through at least 2012, according to AHRQ. For more information, go to http://www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm ■