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5 Current Trends in Patient Safety

By Jeff Terry of GE Healthcare Performance Solutions, Patricia Daughenbaugh, RN, MSN, MBA, of GE Healthcare Performance Solutions Clinical Excellence consulting practice, and Kathy Martin, MBA, of GE Patient Safety Organization | July 20, 2011

The following article is written by Jeff Terry, general manager and managing principal of clinical operations at GE Healthcare Performance Solutions; Patricia Daughenbaugh RN, MSN, MBA, who leads GE Healthcare Performance SolutionsClinical Excellence consulting practice; and Kathy Martin, MBA, managing director ofGE Patient Safety Organization.

The noise about patient safety has never been louder or less coherent.

In April we were told that, "adverse events occur 10 to 100 times more frequently than previously estimated."[1] This after the Office of Inspector General found in December that more than one in four Medicare beneficiaries suffered an adverse event while in hospital.[2] In short, the problem is real, widespread, growing and expensive.

There is also no shortage of good news. A series of efforts inspired by Peter Pronovost's CUSP and Universal Protocol have reduced central line-associated blood stream infections (CBLASI) in the United States by 63 percent since 2008.[3] In England, the National Health System reduced MRSA by 57 percent between 2003 and 2008.[4] There are dozens of similar successes within health systems and hospitals.

So, whether you believe harm to patients is decreasing or climbing, here are five trends we're watching closely.

1. Patient Safety Organizations. PSOs were launched in 2009 and within just one year 100 had been listed by AHRQ. Within two years, 17 had delisted because they could not perform the basic function of PSOs. But, the promise and potential of PSOs remains real and significant. Why? Because only inside a PSO can providers share real stories from the tip of the spear of healthcare delivery without fear of discovery or reprisal. We believe this is transformational because big improvements in safety are about learning. That learning can best take place within PSOs. (Full disclosure: GE is so convinced of the potential of PSOs that we created the GE PSO. The GE PSO emphasizes insights, community and tools to improve.)

2. Implement a Just Culture. Policies that decree behavior change usually fail. Actions taken against those who do harm often backfire. What to do? We find that many organizations are embracing methodologies like Team STEPPS and philosophies like Just Culture. Just Culture, from Outcome Engineering, seeks to create a learning culture that balances transparency and accountability. In a Just Culture, the organization focuses on behaviors that lead to harm rather than bad outcomes. Doing so seems to make great sense but is difficult to operationalize. More often than not, where we see big success, we find organizations that have embraced the Just Culture movement.

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3. Re-examine policies and procedures. Too often, there is a gap between an organization's policies and its reality. For example, we met one hospital which sought to reduce problems of patient misidentification by requiring that four identifiers be examined when labeling a specimen for the lab. The result, of course, was that the staff ignored this requirement and continued to examine two. The larger problem was that this served to normalize deviance, weakening the authority of all policies and procedures in the institution. Another example is hand hygiene compliance. Too many organizations use the secret shopper approach to report greater than 80 percent compliance. Automated measurement finds actual compliance between 30 percent and 50 percent. This begs the question: What is the value of policies that mandate 100 percent compliance when, in practice, it's procedurally possible or acceptable to behave otherwise?

4. Test-drive simulation. Healthcare has lagged other sophisticated industries in the use of simulation. That may be changing. New applications of simulation seem everywhere. Simulation centers train physicians and nurses and teams. Surgical simulators train and test surgeons. Simulation models test new hospital designs before they are built. In short, the sophistication of simulation is beginning to catch up with the complexity of healthcare delivery. For example, at St. Luke's in Houston and Mount Sinai in New York, GE is working with the operators to create simulation models that can be "played forward" to provide the staff with "weather forecasts." These provide the staff with the status of each bed, bay and OR tomorrow so they can make better, non-intuitive decisions today. That matters.

5. Focus on usability. Several decades ago, aviation demonstrated that "safety" is bigger than a single device, cockpit or plane. "Safety" requires a minimum level of standardization between devices. Simply put, we all assume that pulling back on an airplane's yoke causes the nose of the plane to move up. To achieve this and other standardization, aviation organized Commercial Aviation Safety Teams with representation from pilots, airlines, manufacturers and regulators. We face the same challenge in healthcare. For example, if a defibrillator is perfectly safe unto itself, but works differently than the defibrillator in the next OR, it is inherently unsafe. Leaders in healthcare, including Peter Pronovost, are urging healthcare to follow aviation and adopt new approaches to improve usability, standardization and safety.

Patient safety remains one of our great challenges and opportunities. These and other trends may finally demonstrate that safety is getting better, and not worse.

Learn more about GE Healthcare Performance Solutions and the GE Patient Safety Organization.
http://www.gehealthcare.com/euen/services/performance-solutions/index.html
http://www.gehealthcare.com/promo/pso/index.html

[1] David C Classen, et al., "Global trigger tool? shows that adverse events in hospitals may be ten times greater than previously measured," Health Affairs (Project Hope) 30, no. 4 (April 2011): 581-589
[2] Daniel Levinson, "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries" (Department of Health and Human Services Office of the Inspector General, November 2010

[3] Health Aff April 2011 vol. 30 no. 4 628-634, Pronovost et al.

[4] Harutyunyah, UK MRSA Cut in Half. Sep 26, 2008http://www.emaxhealth.com/2/39/24997.html