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VA National Center for Patient Safety

P.O. Box 486
Ann Arbor, MI 48106-0486

Phone: (734) 930-5890

Fax: (734) 930-5877

E-mail: NCPS@va.gov

Web Sites:

Internet: ..www.patientsafety.va.gov

Robin R. Hemphill, M.D., M.P.H.
VHA Chief Safety
and Risk Awareness Officer
Director, VA National Center
for Patient Safety

Editor
Joe Murphy, M.S., APR
Public Affairs Officer

Graphic Design and Copy Editing
Deborah Royal
Visual Information Specialist

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Going an Extra Mile for Patient Safety

By Joe Murphy, NCPS public affairs officer

The VA Greater Los Angeles (GLA) Healthcare System¹ Patient Safety Advisory Team (PSAT) goes the extra mile to coordinate the evaluation, reporting and follow-up actions that involve patient safety and adverse events, encouraging staff members at all levels of the system to participate.

“What we are trying to do is to be as comprehensive as possible about collecting information surrounding incidents or concerns that could affect patient safety or quality of care,” said GLA Neurologist Michael Mahler, M.D., chair of the team.

The group acquires information from numerous sources. “For instance, a patient’s family might talk to the patient advocate,” he said. “And what might initially look like a complaint about customer service could include an underlying issue about quality of care. And the information will be forwarded to us.”

He also noted another example: A daily report that is developed by nursing services. “Every morning the report lists what has happened over night,” said Dr. Mahler, “but those who develop the list have little time to ask questions or go into great detail about problems that may have developed. That’s where our team comes in.”

Meeting at least twice weekly, team members analyze the reports and determine what actions might need to be taken.

“We might say, ‘You know what, the primary team needs to reevaluate this patient’s treatment plan,’ and not because of an error,” he continued. “We may have noticed something the primary team needs to do. For instance, a patient might be in a Community Living Center (CLC) and we say, ‘Is this patient still meeting the criteria for a nursing home setting? Or is he getting too sick and need to be transferred?’ The goal being to correct problems before they happen, support our front-line clinicians and provide better care.”

Incident reports are also received through “VistA” – the Veterans Health Information Systems and Technology Architecture – an integrated information technology system of both nationally mandated and locally adapted software

applications that directly supports patient care at VA medical facilities.

“We still have numerous incidents reported though VistA,” noted Joan Lopes, the system’s chief of quality management. “We never gave that up, though others did. We are a large and complex system and the reports through VistA give us a good overview of day-to-day issues. And we review each significant issue that is reported.”

“More and more people are using VistA, too,” added Dr. Mahler, “so we get a large number of incidents this way, but of course, not all.”

The team also reviews relevant information drawn from the NCPS Patient Safety Information System, a de-identified internal, confidential and non-punitive reporting system. The system, commonly known as “SPOT,” allows NCPS to electronically document and analyze patient safety information from across VA so that lessons learned can benefit the organization.

“What impresses me most about SPOT is that it provides a means of tracking adverse events that occur here at GLA,” said Quality Management Specialist Joann Wortham. “We can retrospectively trend the data and know where areas of improvement lie. Additionally, it provides real-time RCA analysis regarding the event, action plan and follow-up. It’s the complete package.”

Because the team’s approach to patient safety issues has been widely seen as a positive aspect of the GLA’s operations and culture, informal reporting has also been very important.

“For instance, a physician might email Dr. Mahler or myself and say ‘I think this case may merit a review,’ ” said Lopes. “We think these kinds of calls are important and often ask for additional information from those involved.”

Dr. Mahler noted that the PSAT also works with a physician in the system’s full disclosure program. “This gives us another opportunity to understand what might have led to an incident,” he said. “Was it something that had to do with professional competence? Was it really a systems issue? It gives us an opportunity to do this kind of thing, a triage.”

Reducing Falls at VA Boston Healthcare System

By Joe Murphy, APR, NCPS public affairs officer

The VA Boston Healthcare System¹ took a multidisciplinary approach to falls prevention that has resulted in a substantial reduction in the number of falls, following its participation in a virtual breakthrough series.²

“We had a 30 percent decrease in the number of falls, discounting unanticipated physiological falls that cannot be prevented, while falls with major injuries dropped by 50 percent – a significantly higher percentage than we anticipated,” said Vanessa Coronel, R.N., the system’s patient safety nurse and falls prevention coordinator, “and falls, in recent years, have been our most commonly reported adverse event.”

A task force of physicians, nurses, physical therapists, pharmacists, occupational therapists and patient safety staff drew up a list of test changes, to include: sustaining intentional hourly rounding, medication review, reinforcement of safety locks in wheelchairs, and improvement of patient and staff communication. To better convey fall risks, the changes also included use of standardized visual cues and signage at all system facilities.

“On top of striving to provide safer patient care, we project a savings of \$250,000, should the changes be sustained for two years,” said Coronel, “based on our business case analysis.”

In November 2012, the multidisciplinary task force, led by Joan Clifford, deputy nurse executive, rolled out the test changes in two system campuses and in different care settings: Brockton (long-term care) and West Roxbury (acute care).

In Brockton, two wards at the Community Living Center implemented the test changes for nine months: Ward 41-B, a 32-bed long-term care unit, and Ward 42-C, a 15-bed hospice/palliative care unit, which also includes short-term rehabilitation patients.

Nurses perform hourly rounds using a checklist that addresses the needs of high-fall risk patients and makes them less likely to take action on their own, which might result in a fall. “The

checklist is posted in their rooms and includes items such as assisting them with position changes and placing items in reach,” according to Amy Zamiara, L.P.N., 41-B falls champion.

“Our July 2013 target for the two wards was a checklist compliance rate of 90 percent during hourly rounds, but we reached that goal much earlier – in March,” said Brockton Falls Prevention Coordinator Tom Barnes, R.N.

“The checklist was so effective that we immediately started using it in the other wards and now all four have achieved a 90 percent compliance rate,” continued Nancy Weljkovic, R.N., also a Brockton falls prevention coordinator.

Palliative care ward 42-C posed a bigger falls prevention challenge because residents try to maintain their independence like getting out of bed by themselves – actions they’ve always done, but have become difficult to do.

“Residents are also on a pretty fair amount of pain medication, which makes them confused at times or overestimate what they can do,” said Kathleen Olszak-Theobald, R.N., ward falls prevention champion. “In the near future, we plan to proactively involve the resident’s family in falls prevention through education and patient-centered care.”

In West Roxbury, Ward A1, a 23-bed acute care surgical floor, and Ward AG, a 20-bed medical-surgical acute floor, participated in the breakthrough series, coordinated by Associate Chief Nurse James Doelling, R.N.

Aside from hourly rounding, Ward A1 employs visual cues and signage to increase staff awareness of high-fall risk patients. Posters of a pair of non-skid red socks, indicating high risk for falls, are placed at the entrance of the patient’s room and above the patient’s bed. The patients are also to wear red non-skid socks.

“Despite the nature of our patient population, this ward has had no falls with major injuries for years,” said Nurse Manager Gilda Cain, R.N. She also noted that Ward A1 handles patients from 11

specialties including orthopedics, urology and rehabilitation.

“In March 2013, red non-skid socks were made standard in all system facilities as a visual cue to indicate high fall risk, while green non-skid socks indicate low fall risk,” said Ellen McCarthy, R.N., the ward’s falls prevention champion.

Ward AG also conducts post-fall huddles. “The huddle is a debriefing process that seeks answers as to why the fall happened and how can we prevent it happening again,” said ward Falls Prevention Champion Christelle Dragon. “For falls that cannot be prevented, the focus is on reducing the severity of injuries.” A “Fall-Risk Hand-Off” is used in the assignment sheets of Ward AG nurses and is seen as an effective communication tool.

“Ward AG has had no falls with major injuries since its participation in the breakthrough series and was falls-free for the last 38 days in a row, at the end of the breakthrough series,” said Christa Wertz, R.N., the ward’s nurse manager.

“These are the kinds of results we worked hard to achieve and want to sustain and grow our program,” concluded Pamela Bellino, OTR/L, the system’s director of patient safety.

For more information about the health care system’s test of changes and innovations, please contact Vanessa Coronel: vanessa.coronel@va.gov

Notes

1. Learn more about the health care system: <http://www.boston.va.gov/>
2. A virtual breakthrough series allows VA teams, often with members in different geographic locations, to meet by phone or video conference, rather than face-to-face. Such a series allows for effective sharing of ideas while avoiding travel expenses and staff time lost in travel. VA employees interested in further information, email: NCPS@va.gov

Teaming up to Identify and Locate Absent or Missing Patients

By Joe Murphy, NCPS public affairs officer

In July 2013 the Birmingham VA Medical Center formed a team to complete their annual Healthcare Failure Mode Effect Analysis (HFMEA).¹ It was comprised of staff from services believed to have the greatest potential impact on the success of the subject selected for analysis: identifying and searching for an absent or missing patient.

An HFMEA is five-step process used to proactively evaluate a health care process. Specifically designed for use by health care professionals, the process offers users analytical tools such as flow diagramming, decision trees and prioritized scoring systems.

The topic was selected due to the facility location, the number of construction projects underway, the number of near miss events, and the medical center's commitment to safety of Veterans.

"A review of the guidance for managing these events quickly showed the lack of a standardized and coordinated approach," said the facility's Patient Safety Manager Shawana Barnes, R.N., M.S.N. "Due to the urgency of completing our mission, the team chose to meet for three consecutive days: four hours the first day, followed by two eight-hour days. Our goal was to complete the foundation of the project by close of business on the third day."

The team defined an absent patient as a competent patient who leaves a treatment area without the knowledge or permission of staff, but who does not meet the criteria for a missing patient and is not considered incapacitated. A missing patient was defined as an at-risk patient who disappears from an inpatient or outpatient treatment area.

The team's mission was to determine if there were gaps in current processes that needed to be corrected. "We initially felt that we all knew what was expected of us, as well as how other staff would respond when a Veteran was reported to be missing," she said. "But based on our initial conversations, we quickly determined that there were different sets of responses, even within our small group."

For instance, some services used an established internal telephone cascade to alert others within their service. Other services alerted only those in their immediate surroundings, never contacting staff members who were stationed on another

floor. "We also found a difference of opinion regarding which patients should be treated as absent and which should be treated as missing," Barnes noted.

The team discovered that construction areas were a determinant as to whether the Veteran would be identified as missing or absent, "We took a walk through our construction areas, quickly learning that there was more construction going than we had been aware of," she said. "Additionally, we discovered that there were places that might not be explored if staff weren't advised that those areas needed to be searched; basically, more places to hide."

The team determined their top priority was to find a consistent way to inform staff on how best to prevent missing patient events, as well as develop related tools that would be useful and easily accessible.

Having identified the problem and formed the team, the next step was to graphically describe the process in question, developing flow diagrams of each process step and sub-processes.

"We literally started with 'patient comes to the VA hospital' and developed a number steps and sub-steps that could lead to a patient becoming absent or missing," she said.

The team then began a hazard analysis, the next step in the HFMEA process, identifying three major failure modes. Should a major failure occur, it could prevent a sub-process step from being carried out.

In this case, the team found a Veteran could access a restricted area because staff didn't have a consistent process to determine that a Veteran was absent; the failure mode being "Veteran can go into restricted areas." Because of this, the Veteran might also be able to bring unauthorized items back the facility. The other two failure modes were:

- Veterans at risk because of additional factors, such as weather, notification of severe diagnosis, or homelessness
- Communication between provider and patient regarding wait-time, following notice of discharge.

To meet these challenges, the team then developed specific actions and outcome measures.

"Concerning restricted areas, we created a standardized process for ensuring appropriate barriers existed, such as signage and access control," Barnes said. "We also re-enforced 'construction rounds' to document these actions." A check-in/out log was developed to track the whereabouts of Veterans who had the mental and physical capacity to leave the unit without assistance, to include room number and departure/return time.

"When a Veteran is suspected of bringing contraband back into the hospital, after being absent for periods greater than 60 minutes, we developed a policy on who staff should contact," she said, "such as the VA police or the provider, to determine if a patient may have used a banned substance. We also now educate staff on behavioral cues that indicate whether or not a patient should receive a health and wellness check."

The team created a standardized process for determining whether an absent patient had to be evaluated for at-risk factors that would require them to be treated as a missing patient. "And we began monthly missing patient drills to ensure leadership had the opportunity to evaluate the process for vulnerabilities," Barnes said.

Hourly rounding now includes updates on pending labs and procedures. "Veterans and families are also now educated on the discharge process via the GetWellNetwork,² which uses in-room television to provide information on hospital services and other patient-centered concerns," she said.

Having successfully completed the HFMEA, related issues could be explored. "We are now working on such things as a developing a process for a facility lockdown until a missing Veteran is found and a 'live process' telephone service that can be used to provide a description of the Veteran," Barnes concluded.

References

1. For specifics on HFMEA visit: <http://www.patientsafety.va.gov/professionals/onthejob/HFMEA.asp>
2. GetWellNetwork and VA: <http://www.getwellnetwork.com/news/va-taps-getwellnetwork-provide-patient-engagement-platform-transform-care-veterans>

Going an Extra Mile for Patient Safety

(Continued from page 1)

Recognizing problems and tackling them as soon as possible is one of the primary goals of the PSAT. “We want to become aware of problems prospectively, as much as possible, not retrospectively,” said Lopes, “to prevent something with a potential adverse effect from happening. We ask for a lot of information and do a tremendous amount of follow-up.”

She said the reaction to the team’s approach has enhanced the system’s culture of safety. “Even staff that are relatively new will call me or stop one of us in the hallway and say ‘Somebody told me I should talk to you about this thing I am concerned about,’” Lopes noted.

“I lived through a time when people did not tell you what happened or said they didn’t remember; didn’t see anything and so on,” she continued. “It’s very different now. We have a long way to go, we’re not perfect by any means, but have had recent events where a variety of people have come to us and said, ‘I know this and that about it; what about this and what about that.’ All of which can help tie things together and create recommendations that we can and will do, rather than some ideal, pie-in-the-sky thing that sounds great on paper but will never get accomplished.”

“Things like peer reviews and RCAs are very important, don’t get us wrong, but they aren’t built to provide an answer to a problem immediately,” said Dr. Mahler, “where as we have been able get on top of something right away and help develop immediate preventive measures.”

The PSAT has also become involved in seeing that patient safety issues are addressed in the GLA’s training arena. “I’ve started to participate with our graduate medical education committee in order to be a liaison between them, which has representatives from all of our training programs. I’m advising them about how best to develop a culture of safety through their training programs,” he said.

A Communications Problem

Dr. Mahler provided a detailed example of the team’s efforts to resolve a systems problem that involved two clinical areas at his facility. The CLC located on the West Los Angeles campus hosts approximately 150-160 patients on a daily basis. During a two-week period, the PSAT noticed an increase in the number of patients that were moving back and forth between the CLC and the emergency department.

“We expect a certain number of patients will sicken and have to be admitted to the hospital,” he said, “but we noticed a problem.”

For instance, a patient in CLC might have a change to their vital signs or not feel well. “A nurse would think the patient’s mental status had changed and contact the doctor on call, who would say, ‘sounds like a problem, the patient needs to be sent to the emergency room for evaluation.’ They would evaluate and say ‘we really didn’t find anything,’ and send the patient back to the CLC,” he added.

Dr. Mahler noted that in many cases within 6-12 hours later the person would become sicker and have to return to the emergency room and be admitted to the hospital.

“When we looked at individual cases, it wasn’t that we could say ‘the decision to send the patient back to the CLC was clearly the wrong,’” he said. “When we did a chart review, the decision looked good on paper, but there was definitely a problem because sending patients back and forth was clearly increasing.”

Team members took the initiative to discuss the issue with the physicians and nurses who lead the CLC and the emergency department. “We said to them, ‘Look, we’ve noticed this. What do you think is going on? It seems like people are not communicating clearly about what is happening to the patient.’” Dr. Mahler

continued. “So we said, ‘You need to talk together, come up with mechanisms to stop patients bouncing back and forth,’ which is what they did.”

A communication plan was developed and the issue resolved. “This was a systems issue,” he said. “We identified an issue and helped people start to work on it. We all feel good about things happening like this; seeing so many staff members working together to solve a problem.”

Conclusion

Over the years the patient safety team had taken different forms, none of which seemed to work as effectively and the current model. “We had a couple of iterations, neither of which really did what we wanted,” said Lopes, “We really had to ask ourselves, ‘What do we want to be able to do in this group?’”

The group’s goal hadn’t changed, however: to review all reported incidents within the hospital system and determine if any warranted further investigation. “We wanted to find serious events that might rise to the level of an RCA,” she continued, “and create a better way to get other members of our staff involved, regardless of the complexity of our organization.”

Over time, trust in the committee’s efforts has helped to uncover such events, and in doing so, enrich the system’s culture of safety. “One of the benefits of this patient safety collaborative is that it really provides an open and honest dialogue among health care professionals who help ensure the organization continues to provide safe and quality patient care,” concluded Tonia Amos-Jones, Ph.D., R.N., GLA’s patient safety manager.

References

1. Learn more about GLA: <http://www.losangeles.va.gov/>