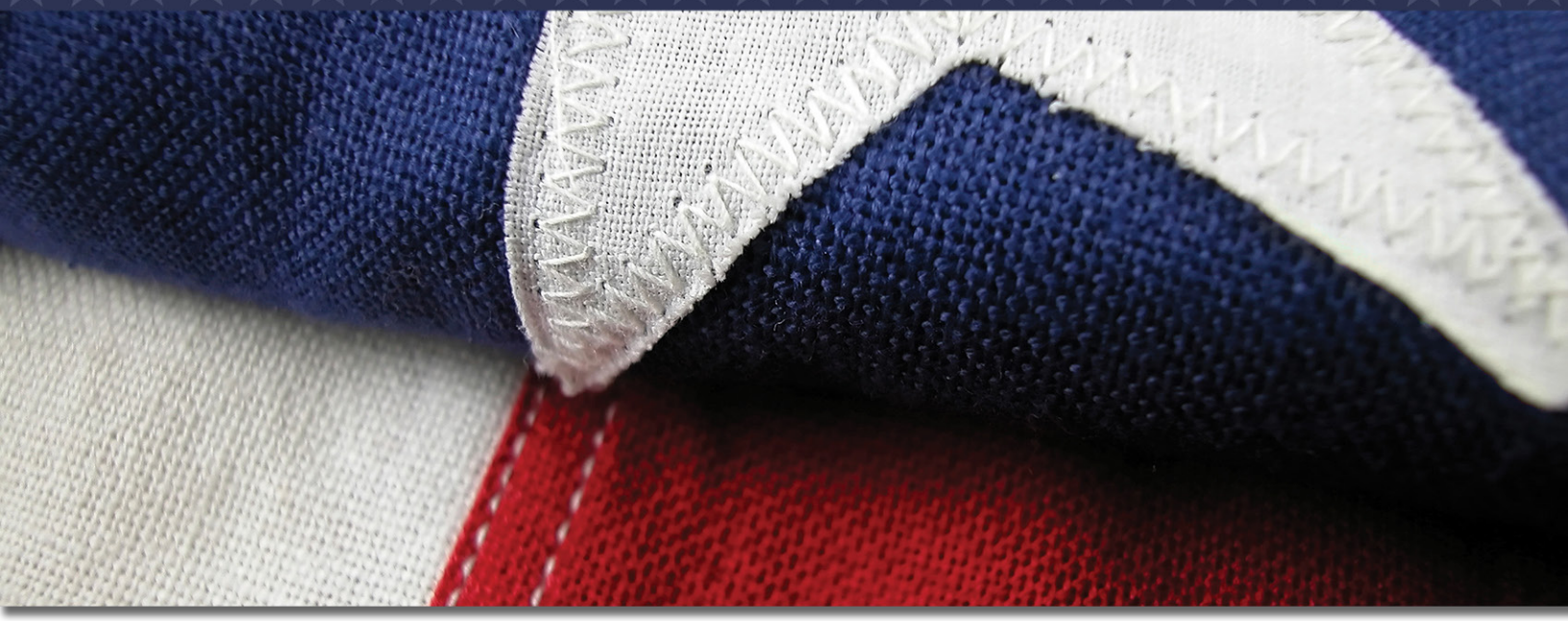
VA National Center for Patient Safety



QSV
VHA OFFICE OF QUALITY, SAFETY AND VALUE

NCPS
VA National Center for Patient Safety
Safer Systems · Safer Care

VA HEALTH CARE
Defining EXCELLENCE in the 21st Century

www.patientsafety.va.gov

VA National Center for Patient Safety

First Do No Harm

The Department of Veterans Affairs (VA) National Center for Patient Safety (NCPS) was established in 1999 to lead VA's patient safety efforts and to develop and nurture a culture of safety throughout the Veterans Health Administration (VHA).

The primary goal of NCPS is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care. NCPS is organizationally located within the VHA Office of Quality, Safety and Value.

A National Team

NCPS' multi-disciplinary team is located in Ann Arbor, Mich., Wash., D.C., and White River Junction, Vt.

NCPS offers expertise on an array of patient safety and related health care issues.

Patient safety officers at VA's 21 regional health care systems and patient safety managers at 153 VA medical centers and other large facilities actively participate in the program.

Veterans Health Administration

NCPS is part of the VHA, the largest integrated health care system in the nation.

The VHA serves the needs of America's Veterans by providing primary and specialized care, as well as related medical and social support services.

It supports innovation, empowerment, productivity and continuous improvement.

Taking a "Systems Approach"

The NCPS program is based on a systems approach to problem solving that focuses on *prevention, not punishment.*

NCPS uses human factors engineering methods and applies concepts from high-reliability organizations, such as aviation, to target and eliminate system vulnerabilities.

Root Cause Analysis

NCPS uses a multi-disciplinary team approach, known as Root Cause Analysis (RCA), to study adverse medical events and close calls (sometimes called "near misses").

The goal of each RCA is to find out *what happened, why it happened,* and *what must be done to prevent it from happening again.* Training programs, cognitive aids, and companion software have been developed by NCPS to support facility RCA teams.

Along similar lines, NCPS developed and implemented the Healthcare Failure Modes and Effect Analysis (HFMEA) process and other tools for health care professionals to use in proactive risk assessment and prevention of harm.

Confidential Reporting System

The NCPS Patient Safety Information System is a de-identified internal, confidential, and non-punitive reporting system.

It allows NCPS to electronically document and analyze patient safety information from across VA so that lessons learned can benefit the organization.

A systems approach to problem solving requires a willingness to report problems or potential problems so that solutions can be developed and implemented.

A combined total of more than 1,000,000 root cause analysis reports and safety reports have been entered into the reporting system since it was established 13 years ago.

Willingness and an avenue to report problems or potential problems is essential to safe care because *we can't fix what we don't know about.*

Publications

NCPS publishes safety alerts and safety advisories on specific issues relating to equipment, medications and procedures that might cause harm to our patients.

Staff members have published more than 230 articles in external periodicals, such as *The Archives of Surgery*, *Emergency Medicine Journal,* and *The Journal of the American Medical Association.*

NCPS also publishes a bimonthly newsletter, *Topics in Patient Safety*® (*TIPS),* that discusses a wide range of patient safety issues. An archive of all *TIPS* issues, 2001 to present, is available on the NCPS Web site.

Patient Safety Training

NCPS' inclusive patient safety training program has been attended by more than 2,800 VA caregivers at the 47 sessions conducted since November 1999.

Professionals from 285 domestic health care institutions or agencies have also attended, including representatives from the Department of Defense, the American College of Surgeons, and the University of Michigan.

Internationally, we have trained representatives from 12 foreign nations, including Denmark and Australia, which subsequently implemented national programs based on the VA model.

VA National Center for Patient Safety
Program and Initiative Highlights

Tool Kits and Cognitive Aids

NCPS has developed a number of tool kits and cognitive aids, available on our Web site, that promote the development of a culture of safety, such as the multimedia "Falls Toolkit" and the "Escape and Elopement Management" cognitive aid.

Patient Safety Directives

NCPS has collaborated with other VA offices to develop directives that provide specific guidelines for patient care, such as "Ensuring Correct Surgery" and "Adverse Drug Event Reporting."

Mental Health Environment of Care Checklist

The checklist was developed for VA medical facilities to review inpatient mental health units for environmental hazards, decreasing the chance a patient could commit suicide or inflict self-harm.

In a 2010 VA study that examined the effectiveness of a standardized checklist for mental health units, a survey of 113 VA facilities indicated that they were able to reduce the risks associated with 5,834 (76 percent) of the identified hazards.

The Daily Plan®

This initiative enhances patient safety by involving patients in their care. It strengthens the communication process and establishes a shared mental model between patients, providers and caregivers. A single patient-centered document is provided to Veterans, outlining what can be expected on a specific day of hospitalization or an ambulatory care visit (including the emergency room and urgent care).

A facility can customize the document and include a number of items relevant to care, such as: medication, allergies, lab and imaging orders, diet, falls risk, skin assessment, immunizations, consults and future appointments.

Patient Safety

Centers of Inquiry

NCPS manages the centers, which are an integral part of our program.

The centers develop, disseminate, and, most importantly, implement clinically relevant innovations that can improve patient safety at VA medical facilities.

A recent example is the creation of a comprehensive moderate sedation toolkit for non-anesthesiologists.

Patient Safety Curriculum

NCPS believes the place to begin learning about patient safety is during early training.

In 2002, NCPS began working with physicians and patient safety personnel from VA medical centers and affiliated universities to develop and test a patient safety curriculum program for residents. From this, NCPS created faculty development workshops; more than 2,000 attendees from VA medical centers and university affiliates have taken them.

The workshops train attendees to teach residents a variety of subjects, including patient safety basics, human factors engineering, simulation-based teamwork and communication training.

Workshops for residents have been developed that include patient safety basics, human factors engineering, simulation-based teamwork and communication training.

Chief Resident in Quality and Safety

Working with the VA Office of Academic Affiliations and The Dartmouth Institute, NCPS has initiated the Chief Resident in Quality and Safety Program.

Twenty-three chief residents from 21 VA Medical Centers (with university affiliation) will participate in a patient safety boot camp, two-way interactive video conferences, and conduct quality improvement projects.

Patient Safety Culture Survey

NCPS performs a national survey every three to five years to measure changes in the patient safety culture: A combined total of more than 153,350 VA employees participated in the 2000, 2005, 2009 and 2011 surveys.

The results have included important developments, such as a significant improvement in senior management's awareness and support for actions that promote patient safety.

Patient Safety Assessment Tool (PSAT)

This Web-based assessment tool allows managers and staff to conduct a detailed assessment of the patient safety program using Joint Commission standards and industry best practices. PSAT provides sections for leadership rounds focusing on the patient care environment and now has a feature that allows for tracking issues through to completion.

Information Technology

NCPS collaborated in the creation of the Bar Code Resource Office and the Informatics Patient Safety Office and continues to partner with both offices to promote the use of human factors engineering design principles in software and other information technologies.

NCPS is playing an integral part in a number of informatics initiatives, such as redesign of VA's pioneering electronic health record system. Staff members are also working to secure prioritization of numerous other patient safety information technology projects.

NCPS Pharmacists

NCPS pharmacists support VA medical center compliance with Joint Commission National Patient Safety Goals, to include accurate and complete reconciliation of a patient's medications across the continuum of care.

They conducted a national effort to develop a single standardized prescription label for use within VA in 2011, directly involving Veterans in the process.

The goal was to determine how best to serve the VA's 4.4 million pharmacy users through the redesign of labels affixed to nearly 122 million prescriptions dispensed each year. A trial of the new format was conducted in 2012.

Based on the study and trail, a new standardized patient-centric prescription label roll-out began in 2013 and is scheduled for completion by the end of 2014.

Product Recall Office

Located within NCPS, VA's Product Recall Office (PRO) is tasked to manage recalls of all food items, drugs, medical devices and consumable products initiated by manufacturers or the FDA that are applicable to VA.

The Recall Office receives more than 12,500 recall notices from a variety of sources annually, of which about 10 percent apply to the VA.

Following its December 2008 establishment at NCPS, recalls compliance – removing recalled products from the supply chain – has risen to and is holding at 99 percent.

Patient Safety Fellowships

The VA Office of Academic Affiliations (OAA) teamed with us to offer one-year fellowships in patient safety. NCPS manages the program; OAA provides the funding.

Fifty-five have been selected as fellows since the program began in 2007. Projects have included: evaluation of falls injuries and prevention strategies; curriculum for physician assistants.

Cornerstone Recognition Program

The program began in fiscal year 2008 to incentivize VA facilities to complete stronger RCAs. The recognition criteria focus on timeliness and strength of actions, as well as reporting back on the impact of actions taken. Facilities can earn bronze, silver or gold awards, based on the number of RCAs completed and the quality of the RCAs.

Clinical Team Training

The Clinical Team Training (CTT) program improves patient safety by facilitating clear and timely communication through collaborative teamwork in the clinical workplace.

Aimed at a multi-disciplinary group of front-line health care providers, the program is based on techniques used in aviation's Crew Resource Management (CRM) training.

CRM was implemented by the airline industry in the 1980s after a series of highly publicized accidents resulted from poor communication and team decision making, not from mechanical malfunctions. Today, the airlines enjoy an exemplary safety record, due in large part to the implementation of CRM methodologies.

CTT has demonstrated effectiveness in the clinical environment. A 2010 VA study published in the Journal of the American Medical Association found a significant decrease in the annual surgical mortality rate in groups trained in CTT methods, as opposed to untrained groups; also, the longer these methods had been practiced at a medical facility, the greater the decrease in mortality.

CTT methods were also used to improve communication and teamwork on 11 nursing units at nine VA facilities during another training program piloted in 2010, which included a six-hour learning session and two-hour clinical simulations using high-fidelity patient simulators.

Clinical results of the pilot program included significant decreases in hospital acquired pressure ulcers, failure to rescue events, and medication errors. These results have been published in *The Journal of Nursing Administration* (2011, 2012 and 2013) and *The Journal of Nursing Management* (2012).

Since 2005, the CTT methods have been used to train more than 16,500 staff at VA medical facilities nationwide.

VA National Center for Patient Safety

24 Frank Lloyd Wright Dr., M2100
Post Office Box 486
Ann Arbor, MI 48106-0486

Phone: (734) 930-5890
Fax: (734) 930-5877

E-mail: ncps@va.gov
www.patientsafety.va.gov

NCPS
VA National Center for Patient Safety

Safer Systems • Safer Care