



VA National Center for Patient Safety Topics in Patient Safety®

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

Editor

Derek D. Atkinson, VHA-CM
Public Affairs Officer

Graphic Design and Copy Editor

Deborah D. Royal, VHA-CM
Visual Information Specialist

TIPS® is published quarterly by the VA National Center for Patient Safety. As the official patient safety newsletter of the Department of Veterans Affairs, it is meant to be a source of patient safety information for all VA employees. Opinions of contributors are not necessarily those of the VA. Suggestions and articles are always welcome.

Thanks to all contributors and those NCPS program managers and analysts who offered their time and effort to review and comment on these TIPS® articles prior to publication.

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

Internet www.patientsafety.va.gov

Intranet vawww.ncps.med.va.gov



CONTENTS

Not Just Lip Service – Leadership in VA Gets Serious About High Reliability	Pages 1-3
Saving Lives: One Reversal at a Time	Pages 3-4
Putting a Face to a Name	Page 4

Not Just Lip Service – Leadership in VA Gets Serious About High Reliability

Gary L. Sculli, MSN, ATP, director of clinical training programs, and
Derek D. Atkinson, public affairs officer, VA National Center for Patient Safety

The Harry S. Truman Memorial Veterans Hospital in Columbia, Missouri is at the 'tip of the spear' in the effort to implement high-reliability practices into the daily operations of the medical center. Gary Sculli, VA National Center for Patient Safety (NCPS) program manager and director of clinical training programs, recently discussed this effort with Truman's associate director – Veteran and human factors engineer – Rob Ritter.

Currently you are the only facility in the nation within the VHA system who has administered Clinical Team Training (CTT) to every clinical area. That's quite an accomplishment don't you think?

I believe the commitment to the High Reliability Organization (HRO) pathway is widespread throughout VHA. Our VISN began systematic implementation of the HRO model in May of 2016, with outstanding training and an excellent 23 module toolkit for its seven VA medical centers. Our VISN director, Dr. William Patterson, and VISN 15 patient safety officer, Julie Madere, not only made this a top VISN priority, but they also developed and provided a practical framework that really helped with implementation.

We at Truman VA were fortunate to begin our partnership with NCPS in March 2015. It's an enormous

commitment of time and energy, but what could be more important than patient safety? We could not have accomplished this without the resources and expertise of NCPS; their training, consultation, guidance and assistance have made the difference, and helped keep us on a focused course. "Accomplishment" is probably not the right word, since it implies completion; initial implementation was scheduled to take place over a three-year period and sustainment after that period must remain a relentless effort.

What made you create a position dedicated to the continued and perpetual administration of CTT?

Advancing as an HRO is much more than providing CTT. After each clinical area is trained, a year-long project is selected by the staff to improve safe patient care; this requires organizing, coaching and guiding clinical groups, and then monitoring progress and providing assistance where needed. These projects have been fantastic, by the way, and have been instrumental in gaining physician and leadership buy-in that have really made the difference for countless improvements for patients and staff. Simulation and sustainment training are also involved.

A project of this scale and importance is not possible without dedicated resources to lead our

efforts. As we progressed, we knew we'd have more than a dozen clinical groups at various stages of the process, and coordinating the team efforts would be a full-time job. Furthermore, besides this strategic initiative, we needed to maintain the day-to-day focus on coordination of patient safety work, such as managing patient incident reports, guiding root cause analyses, etc. Both the tactical and strategic work could not be led by one person.

We hired a new Patient Safety Manager in November 2015, about 8 months after we began the CTT initiative, so that Tim Anderson, then Patient Safety Supervisor, could focus almost exclusively on leading the HRO project at the medical center. We reassigned 0.5 FTE of a Quality Management (QM) Program Support Assistant to the HRO team in March 2016; and in April 2017, we hired a VISN-funded RN to focus almost exclusively on Clinical System Redesign for HRO projects.

Are you seeing results from not only CTT but from some of the other high-reliability practices you've enacted as part of the high-reliability hospital (HRH) project?

While we were establishing CTT, we also worked with Dr. Michael Schwartz and the Center for Healthcare Organization and Implementation Research (CHOIR) to implement leveraging frontline expertise (LFLE) in quality and safety. This dovetailed nicely with several characteristics of an HRO as taught in CTT, such as "sensitivity to operations" and "deference to expertise." As part of the LFLE initiative, we visited clinical areas to conduct two-hour work system observations, and asked questions of front-line staff about what concerns and barriers they may have regarding safe patient care. HROs know that the best picture of the current situation comes from the front line. Front-line employees are closer to



Truman VA staff participate in a simulation scenario as part of the High Reliability Hospital (HRH) project.

the work than executive leadership and have a clearer understanding of the risks that staff and patients face every day, so they are better able to recognize and identify opportunities for improvement. Through these listening activities, we were able to develop trust, demonstrate empathy, understanding and, most importantly, identify through first-hand observation, significant resources and changes that were needed to help staff deliver safer care. When you see it for yourself, and you develop that connection with the staff members who report the challenge, you really get immediate buy-in to fix the problem(s).

We have also begun a practice whereby executive leaders review close calls at morning report. Not only does this keep patient safety at the forefront of our service chiefs and key staff's minds, but it also helps to recognize and thank individual staff, who identify areas where the system needs review to mitigate risk.

Please talk about the HRH project for a minute. What has it meant to you as a leader and to your facility?

The HRH program makes me proud to work at a VA medical

center. Despite the negative media and congressional reports of the past few years, VHA is committed to continuous improvement in quality and safety. The HRH project emphasizes safety improvements that are most important to Truman VA patients and staff. I am so happy to be part of a team that is willing to put such enormous effort and resources into this area.

There is no doubt that we need NCPS to develop the resources and plan to offer the HRH project to all VA medical centers. Although I've only been with VHA for five years, this is the best program I've seen come out of VA Central Office.

Why are you so invested in sustaining the high-reliability practices you learned while partnering with NCPS?

Staff feel safer in speaking up about safety concerns, and they now have simple tools to do so. Because of Just Culture seminars and CTT curriculum, staff also feel safer reporting close calls and patient harm so that we can take action to mitigate risks. This improvement in communication and trust alone is worth all of the hard work – even the police service, who attended

the training, are now consistently using a briefing checklist and shift change handoff.

A “Teamwork and Safety Climate” survey of each clinical area is taken before and after they complete CTT and the improvements we have seen in the post-surveys are truly remarkable and gratifying. We’ve seen enormous improvements in staff feedback about “nursing input being well-received,” “having support needed from others to care for patients,” “feeling encouraged by colleagues to report any patient safety concerns I may have,” “medical errors are handled appropriately here,” and many other areas. This is the most important work we do, and this training has made a big difference.

Talk to me about safety forums – what are they and do you plan to keep doing them?

As part of the HRH project, we’ve implemented monthly safety forums, where we pick a topic in patient safety we think the staff will find interesting or an area where we want to build greater awareness. Staff have an opportunity to be part of the conversation on topics where they have concerns and can provide suggestions as to how they think we can improve. Sometimes the topic is from a root cause analysis, patient incident report, or from recent trends in patient safety. I have been so surprised to see such great attendance, widespread participation in the discussions during Q&A, and positive feedback from the participants. It has been gratifying to see that our staff find these forums to be value added. We have found that staff want to be engaged in these dialogues and the communication and problem-solving I’ve witnessed is remarkable.

How are you implementing Just Culture principles on a regular basis?

We have adopted Just Culture principles as the format for responding to nearly all patient incident reports. It’s impressive to see, on a daily basis, leaders of all clinical areas conducting analysis of processes and staff actions that apply Just Culture principles to solutions and follow-up. The consoling, coaching, systems review and fair approach to considering formal discipline is very encouraging. We know that disciplining staff when they make errors while working appropriately and in the patient’s best interest serves no one and will most likely hinder safety reporting down the line.

You seem to understand the critical importance of leadership in patient safety – talk to me about that?

Some of us were nervous about sustaining the project when Wade Vlosich, the director who originally forged our partnership with NCPS, took a new director’s position at Oklahoma City VAMC. But our new director, David Isaacks, quickly embraced the HRH initiative and has been instrumental with a seamless transition and strong support. Tim Anderson, our on-site HRH project manager, has been instrumental to our successful collaboration.

In every publication I’ve read about HROs, leadership engagement is listed as the critical success factor. General Jeff Taliaferro, one of my former bosses, often said that when something is important, you need to talk about it, and talk about it, and talk about it, until people’s eyes roll into the back of their heads. Communicating priorities is one of the most important things a leader can do, and it must be done in every forum and using every available method. Patient safety is one of those areas we need to continually discuss, and we need to connect it with the day-to-day actions of every staff member. In addition, we need to be specific about what we want/need staff to do. It’s not just the CEO who needs to be out front speaking about why this is important – the chief of staff, nurse executive, service chiefs, and physician and nursing leaders all need to be talking about what we are doing for patient safety, how it’s improving our care and how our work environment has improved as a result.

Truman VAMC will continue to partner with NCPS in the High Reliability Hospital project through 2018.

Saving Lives: One Reversal at a Time

Pam Bellino, OTR/L, patient safety manager, VA Boston Healthcare System
Derek D. Atkinson, public affairs officer, VA National Center for Patient Safety

The nation’s growing opioid epidemic has led to devastating morbidity and mortality. Massachusetts has been particularly impacted as opioid overdose is now the leading cause of death in the state, surpassing the combined number of motor vehicle and gun fatalities. From the year 2000 through 2014, the state witnessed a 251 percent increase in overdose

deaths, with 1,256 in 2014.¹ Heroin has become a cheap and readily available alternative to prescription opioid drugs, further fueling the opioid epidemic.

The term “opioid” describes drugs that originate naturally from the opium poppy plant, called opiates (e.g., heroin, morphine, codeine) or synthetic drugs that produce opiate-like effects (e.g., oxycodone, Percocet,

fentanyl). Although opioids are effective in managing pain, they also depress respiration and overdoses readily produce respiratory arrest.

Fortunately, there is a drug, Intranasal (IN) Naloxone, known as Narcan, which if administered promptly and appropriately, can reverse opioid overdose by blocking opioid receptors in the brain to restore respirations and prevent death.

Veterans have a high prevalence of substance use disorders and are vulnerable to opioid abuse, dependence and overdose. In response to the opioid epidemic, VA and state licensing agencies have actively promoted safe and effective practices to minimize the risks of abuse. Providers are utilizing alternative non-opioid pain treatments, prescribing opioids only when necessary, consulting state prescription drug monitoring databases to avoid duplicate opioid prescriptions, and referring patients to substance abuse and mental health treatment.

In March of 2015, VA Boston began encountering an increased number of patients and visitors who were unresponsive due to opioid overdose. The first responders for many of these events were VA police. Reversal of overdoses was delayed until the medical emergency team arrived, because the police did not carry IN Naloxone. To address this patient safety concern, a task force was established in August 2015 to develop a program to equip VA Boston police with IN Naloxone. After just three months, a new local policy was in place, and all VA Boston Police were carrying two doses of IN Naloxone on their belt. Within weeks, VA police began to reverse opioid overdoses.

After equipping VA police with IN Naloxone, deployment throughout the health care system was the next step in the fight against opioid overdose. However, there were challenges in expanding access to high-risk

areas while complying with The Joint Commission standards on securing non-controlled medications from unauthorized individuals.² Non-controlled substances may be kept in a secure area, where staff is providing care or is present, and where patients and visitors are not allowed access without supervision or presence of a health care professional. Many hospital areas where overdoses might occur do not meet these conditions. Therefore, IN Naloxone kits were deployed in wall-mounted, locked medication boxes within residential homes, community-based outpatient clinics and outpatient drug treatment programs.

However, the use of lock boxes in an emergency situation poses a significant problem, because they need to be found and unlocked quickly, creating a barrier to the timely administration of lifesaving medication. The wide deployment of automated external defibrillators (AEDs) across medical centers and many public places presented an opportunity to piggyback on an existing, widely-recognized lifesaving measure.

Since the AED cabinets were not locked, The Joint Commission standards for deployment of nonscheduled medications in secure locations needed to be addressed. This was done by requesting and receiving approval of a Medication Security Standard exception for IN Naloxone, provided that certain conditions were met.¹

The first AED with IN Naloxone was deployed on February 22, 2016 at the West Roxbury canteen as a trial of the new process. Daily checks were performed by patient safety staff for one month to assure that the daily log was being completed and the integrity of the AED cabinet was maintained. After successfully completing the pilot, VA Boston began to deploy IN Naloxone in the areas identified through their risk assessment.

To date, IN Naloxone has been deployed to 41 out of 50 AED cabinets throughout the VA Boston Healthcare System which has contributed to 92 overdose reversals (as reported by Veterans). This process is now being implemented in VISN 8, with the goal to promulgate throughout the country. It has and will continue to save Veterans' lives, and VA Boston is proud to be at the forefront of the nation's fight against the opioid epidemic.

References

1. AED Cabinet Naloxone Program Toolkit. <http://vawww.ncps.med.va.gov/tools/AEDNaloxoneToolkit.docx>
2. The Joint Commission Manual e-edition (2017). Accreditation requirements: Medication management. <https://e-edition.jcrinc.com/MainContent.aspx> retrieved on August 3, 2018.

Putting a Face to a Name: Your Patient Safety Team



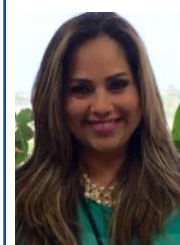
**Teresa Pickett,
RN, MA, CPHQ**

Patient Safety Manager
Mountain Home VA
Healthcare System
(Johnson City, TN)
35 years with VA, 11
years in patient safety



**Quavonia Chaison,
MSN, RN-BC, PMHN**

Patient Safety Manager
Michael E. DeBakey
VAMC (Houston)
11 years with VA, 1 year
in patient safety



**Esmeralda Martinez,
RN, ADN, BSN**

Patient Safety Clinician
VA Texas Coastal Bend
Health Care System
(Harlingen)
20 years in VA, 8 years in
patient safety