Pittsburgh Regional Healthcare Initiative
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Naida Grunden, editor

Progress and challenges

Meetings: moving 'em on out

The coffee and cream cheese are tepid, the bagels not so fresh. Welcome to the monthly meeting of the Patient Safety Committee, required under Pennsylvania's Act 13. Department leaders sit in chairs around a table, doors closed, and consider problems that have come to light since last month's meeting. Discussion ensues, and actions are proposed, usually in the absence of the people who were there when the problem occurred. After an hour or two, the meeting's adjourned.

Sound familiar?

Starting next month, the Patient Safety Committee meetings at LifeCare Hospitals of Pittsburgh will take place, at least in part, on the floor of the hospital, where the care of patients occurs. This 155-bed hospital, the largest facility in the LifeCare national system, meets the special needs of both medically complex patients and those in need of behavioral health programs for 25 days or more. The issues of safe medication administration and an infection-free environment are particularly important for their patients.

First things first

Because medication errors and infections can have such a devastating effect on their patients, for the past year, LifeCare has been generating "Daily Reports" for all leaders. These reviews describe medication problems identified by staff—right down to the latent conditions that might lead to an error. They're in the process of doing the same kind of identification with infection. Because these data are usually only 24 hours old, the details can be related and the conditions that led to the problem can be addressed right away.

As a result, LifeCare has made gains in medication safety. In 2002, only 167 medication errors reached their internal information system, 71% of which reached the patient (C, D & E errors). In 2003, two things happened: information on incidents increased five-fold; and less than 28% of errors reached the patient. Also, information entered about potential problems (A & B errors) increased—from 23% in 2002 to 72% in 2003. Errors did not increase: information about them did. Increasing the flow of information about errors and potential errors can allow a clearer picture of underlying system problems to emerge, where they can be dealt with more quickly.

Moving on out with meetings

Recently 15 LifeCare leaders and staff members completed PRHI's intensive, week-long Perfecting Patient Care (PPC) University, offered at their site by PRHI. One central tenet of the PPC system is close observation, a challenge to workers, especially managers, to go visit the "shop floor" in person to see how people actually do the work. Among those who went to the floor to observe staffers doing their work were CEO Cliff Orme, Risk Manager Carolyn Griffin, Director of Professional Services Christine Quinn, and Chief Clinical Officer Elaine Hatfield.

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—Marty Kurth, RN
PRHI Team Leader

"We found more than we were looking for," said Quinn. "We discovered lots of things we could be doing to make it easier for people to do their work."

Others commented on their observations:

I saw that nurses work hard and do a good job.

They have to do a lot of running around. It wastes a lot of their time.

They didn't always have the tools they needed on hand to get the job done.

Next month's Patient Safety Committee will be different in several ways. It will include a wider cross-section of staff members, and they will go out on a guided observation somewhere in their own hospital, to see how work is actually done. Nurses may find themselves observing pharmacists, and pharmacists observing nurses. Not only do the observations promote a deeper understanding of the problems, but a deeper respect for the professionalism each person brings to the work.

PRHI Team Leader, Marty Kurth says, "In one experiment at another hospital, a nurse racked up over five miles on her pedometer in one shift. When you see—*really see*—what people have to do to get their work done, you stop wondering why and start thinking about ways it could be different and better for nurse and patient."

Case in point

From meeting to problem-solving: a very recent example

Once a week for an hour, the MedMARx committee at LifeCare meets to hear about medication problems that have occurred that week across the entire institution, and consider ways to fix them. On the committee are LifeCare's CEO, Cliff Orme, and other senior administrators including the risk manager, nurse managers, pharmacy representatives, educators, and a house physician.

One nurse asked about how pharmacy orders are verified. She suspected that problems catalogued as *omissions* or *delays* might really be problems communicating whether an order had actually been received in the pharmacy. Maybe every floor wasn't processing pharmacy orders the same way.

During that meeting, something clicked—or snapped.

Sometimes an empty conference room signifies that people are out on the floor observing and solving problems—"where the action is."

No longer content to count the numbers in a meeting room, the group decided to disband on the spot, split into four groups, and go immediately to the four nursing units to observe the entire transcription process for 30 minutes. The objective: *find out what the problem really was*.

Later that afternoon, the committee regrouped to compare what they'd learned. Their findings surprised them. Processes for sending orders were not working the way they were supposed to. Some further digging revealed why.

LifeCare recently invested in a system that enabled copy machines on the nursing units to scan prescriptions to e-mail directly to the pharmacy. Scanned orders arrive in the pharmacy in much more legible condition than faxes. The hidden problem: e-mailed confirmations from the pharmacy were not easy to find, open, print, and place in patients' charts. There was confusion.

With input from people on the floor and people in the Information Services Department, the group designed an experiment right then and chose one unit for trial. On that unit, confirmation sheets from the pharmacy print out automatically now. Unit secretaries place them in patients' charts, and nurses have the verification right there every time: there's no confusion—it's *yes* or *no*. Since this measure was instituted on the unit, *omissions* and *delays* have decreased. Some further "tweaking" is bound to occur: the experiment is just a week old at this writing. But as soon as the experiment is deemed satisfactory by the nursing unit and the pharmacy, it will be rolled out on the other units.