Pittsburgh Regional Healthcare Initiative

Reaching for Pre-Disaster Transformation

Can a hospital create a climate for change before a sentinel event?

Reprinted from *PRHI Executive Summary*, March 2003
Naida Grunden, editor

Reaching for pre-disaster transformation

Recent headlines mourned the death of Jésica Santillán, a 17-year-old patient at the respected heart-lung bypass unit of Duke University Medical Center. Jésica died as the result of a fundamental medical error: she received a heart and lungs from a donor of a different blood type.

In the wake of Jésica's death, a question arises: will Duke use this tragedy as an opportunity to find out exactly how this cascade of errors led to disaster?

In September 2002, James Conway, COO of the Dana-Farber Cancer Institute, inspired PRHI leaders with the dramatic story of how that institution began to transform in patient safety and quality, a transformation that continues. Its genesis came through institution-wide reflection following the death of Betsy Lehman, a beloved health reporter for the Boston *Globe*. Under treatment for breast cancer, Betsy died of a massive chemotherapy overdose.

As a result of the ensuing institution-wide self-examination, healthcare workers at Dana-Farber now routinely report errors and problems and fix them. Patients serve on quality committees alongside healthcare providers and others. The hospital's error rates have plummeted, while the quality of care continues to improve.

If investigators at Duke ask the key question—not who, but ***why***—they can begin to find the root causes of each breakdown in the system that allowed the blood-typing error to slip through. They can fix the root causes. Most important, Duke can seize the international, headline-grabbing "sentinel event" involving Jésica Santillán, as Dana-Farber did with Betsy Lehman, as a rallying cry to press forward with profound systemic change.

Some forward-looking hospital leaders in Pittsburgh have begun the quest to find, report and remedy errors in new ways. At Allegheny General Hospital, physician leaders held a press conference and shared information widely among PRHI partners when a problem with bronchoscopes threatened patient health.

Leader declarations

Most dramatic improvement efforts, such as those on the Perfecting Patient Care Learning Lines, are done by the workers closest to the action. Yet the importance of leadership—as a precondition and then as non-delegated, continuous involvement—can't be overstated.

Transformation is possible when a leader steps out to proclaim that, from this point forward, things will be different. Patients in the institution will not be subject to medication errors and will not contract infections while they are in the hospital. Leaders must also acknowledge the devastating effects of mistakes on hard-working, well intentioned caregivers.

Change in the air

Two years ago, LifeCare Hospitals of Pittsburgh instituted the "error-free medication stay" as a scorecard indicator. However LifeCare CEO, Cliff Orme, was dissatisfied with the progress.

"We got better at reporting medication errors, and we could see the magnitude of the problem," said Orme, "but I didn't feel we were any closer to eliminating them."

In response to Orme's request, PRHI field managers helped LifeCare simulate a real-time

reporting system using MedMARx. One February afternoon, Orme led a group—consisting of team coordinators, nurse educators, administrators, and PRHI staffers—as they considered what it would be like to capture and review every error every day. The team began to see how it could be done. Their optimism prompted LifeCare's decision to institute real-time medication error reporting and resolution.

"The simulation was enlightening for all of us," says Orme. "It helped us realize just how complex our medication process is. We now have an idea of what it will take to fix these errors before we have a chance to repeat them."

Orme reported back to the employees, stating: **No one who works here should ever have to be subjected to a work environment that tolerates medication errors**.

He announced that LifeCare will institute real-time medication error reporting and pledged to begin fixing errors within 24 hours.

Eliminating abbreviations

As part of the drive to reduce medication errors, LifeCare adopted the policy that prohibits physician orders that include dangerous abbreviations. The message was clear: **Dangerous abbreviations are unacceptable. They compromise the health and safety of our patients.**

In his statement to employees, Orme acknowledged the awkwardness of confronting physicians.

"I hate to confront people just as much as the next person," he said. "I empathize with nurses who must tell the physician, 'I'm sorry, Dr. ____, I need you to clarify this order because it contains a dangerous abbreviation.'"

The statement promised that Orme—along with Dr. Sotos, chief of the medical staff and several other physicians, by name—would back up nurses and pharmacists refusing to accept the abbreviations.

Orme followed the declarations with an article in the employee newsletter, reprinted on the facing page.

Learning opportunities

LifeCare is an licensed acute care hospital that specializes in the care of protocol-resistant patients. The facility administers over 70,000 medication doses each month. LifeCare will provide an unique laboratory where other PRHI partners can come to learn. Orme has pledged that once real-time reporting begins, in tandem with a rapid way for everyone in the organization to solve problems to root cause, PRHI partners will be invited to observe. As the learning proliferates, medication errors can be reduced throughout the region.

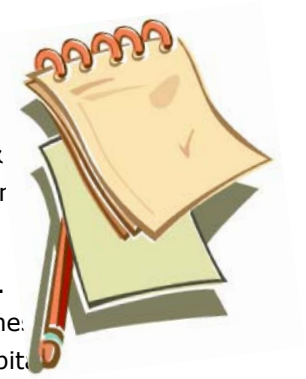
The key: leadership

PRHI offers resources to partners interested in transforming their institutions without waiting for a catastrophe on the scale of a Jésica Santillán or a Betsy Lehman. As a region we can begin now to tackle complex systems, and the problems and errors they engender. The key will be leadership.

Transformation: what might it look like?

One Error is One Error Too Many

From LifeCare Employee Bulletin, *Grapevine*, March 3, 2003



Last month I made two important declarations. First, our *employees should' subjected to a work environment that tolerates med errors*. And, second, at L *dangerous abbreviations is unacceptable*. Making these statements is the easy Making sure what I said is put into practice will be the challenge. LifeCare is c improve the way we care for people's health. The only way I know to live our r statement is to fundamentally change the way we conduct business.

Traditionally, hospitals have tolerated systems that allow for errors to occur. LifeCare, we are behind the times, compared to industry, in addressing breache quality. The public is outraged. Far too many people develop infections in hospit suffer adverse drug reactions because healthcare leaders fail to put in place systems to eliminate the causes of errors.

As CEO of LifeCare Hospitals of Pittsburgh, I am committed to implement a real-time med error reporting system. We will find and eliminate causes of errors until we get to zero. That is the goal. Sure, we can hide behind statistics that show our performance is better than national averages. But this is not right. If you or your loved one suffered the consequence of even a single mistake you would say, "One error is one error too many."

Representatives of the Pittsburgh Regional Healthcare Initiative (PRHI) tell us that even though we are reporting more med errors than we used to, we are still dramatically underreporting. They believe if we reported every error that we would have roughly 40 errors a day! Knowing this, if I don't act swiftly to address this problem, I am negligent in my responsibilities to our patients. The only reason I can sleep at night is now I know we have a tool to help us identify and eliminate the causes of these med errors. We have a program called MedMAR$_X$. Soon I will be able to see, on a daily basis, med errors as they occur. I will also be able to determine what has been done ***today*** to make sure we don't repeat the same mistake ***tomorrow***. This program will get us headed in the right direction.

Please, if you commit an error, report it so that we can implement systems to help you and your coworkers reduce the probability of making the same mistake twice. Then, hopefully, you can leave at the end of your shift knowing you have done everything in your power to protect your patients. We have a lot of work ahead of us.

—Clifton Orme, CEO

LifeCare Hospitals of Pittsburgh

Pittsburgh Regional Healthcare Initiative

Centre City Tower
650 Smithfield Street, Suite 2150
Pittsburgh, PA 15222
Phone: 412-535-6293

Fax: 412-535-0295
Website: ***w w w . p r h i . o r g***