

# The Culture of Safety

Clinical knowledge and even the right IT aren't enough to guarantee patient safety. A fundamental cultural shift is required.

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A patient arrives at the hospital with acute myocardial infarction. He is treated, stabilized over several days and sent home. Although it is known that beta-blockers can reduce further risk of death from another cardiac episode, no beta-blockers are prescribed. Several weeks later, the patient has another massive infarction and dies.

Is this a medical error or near miss? By many definitions, no. But what if the patient had received beta-blockers, known to be effective medicine against heart failure?

The West Virginia Medical Institute (WVMI) is a not-for-profit organization of more than 300 professionals who work with health plans, providers and consumers toward quality improvement in healthcare. WVMI researchers have discovered that clinical knowledge is not always the answer to our most pressing healthcare problems. Many times we have the knowledge, but we are missing the processes.

Does the hospital have the processes in place to ensure that patients receive appropriate treatment? Caregivers, even when they have a patient record, sometimes believe that beta-blockers were administered even when they were not. Only careful review of charts may show that standards were not followed. This is a situation of knowledge versus process: The caregiver *knows* the beta-blocker could have saved a life, and this knowledge prevents him from be-

lieving that no process was in place to ensure the use of beta-blockers.

Changing this culture isn't easy. It requires a new way of thinking about "what we're missing" and a careful approach to instituting

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change. The first step is to acknowledge a possible gap between accepted medical science and actual practice.

## Significance of Omission

The National Patient Safety Foundation (NPSF) and many other agencies have encouraged healthcare institutions to regard omissions as potential areas for improvement. The failure to administer the pneumococcal vaccine to pneumonia patients and those with certain conditions (such as diabetic patients) is now widely considered to be an error of omission.

WVMI received a national prize in 2002 from NPSF based on its omission report and efforts to improve the use of

this vaccine. WVMI found that fewer than 10 percent of pneumonia patients admitted to hospitals were receiving the vaccine. Today, WVMI and its partners have increased the percentage of patients who are screened for the vaccination by 35 percent, and use of the vaccine has increased significantly in pneumonia patients.

What's crucial, however, is that knowledge of the omission is transformed into a protocol for ensuring that proper procedures are followed. The healthcare workers who were sure the beta-blocker was routinely administered in their institutions—even when it wasn't—are proof: Knowledge is not enough. A patient safety culture already in place is required to put knowledge into action. The culture that will truly drive healthcare process improvement will include attention not just to omissions, but also to near misses.

## Required for Cultural Change

WVMI works with DoctorQuality, a Conshohocken, Pa.-based medical error tracking and analysis company, to promote that cultural shift within all of West Virginia's hospitals. WVMI offers to these hospitals DoctorQuality's technology system for tracking near misses and events related not just to medication errors, but to all possible errors in a hospital system.

Patient safety solutions can be identified when the following have been achieved:

**Culture.** Creating a nonpunitive, positive culture around patient safety, which can be accomplished

For more information about Risk Prevention and Management from DoctorQuality, [www.rsleads.com/307-207](http://www.rsleads.com/307-207)

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through tactics such as education about the importance of error reporting, a rewards/recognition system for top event-reporters, and communication of the success of data-driven changes so employees will know their reporting efforts are working.

**Data Capture.** Collecting and analyzing the data across a specific hospital or healthcare organization, as well as by individual care unit, for the most accurate picture of an organization's opportunities for quality improvement. Collection should be simple and fast; it should take two to three minutes.

**Information.** Understanding what the organization's data mean in the context of the larger picture. DoctorQuality's national aggregate database is already yielding insights for WVMI into the origins of a number of errors.

**Solutions.** Providing immediate procedural and protocol solutions to the most pressing problems the data have uncovered, and planning for and implementing applicable technologies to areas where process improvement alone can't solve the problem.

Without all those factors in place, the organization risks missing something.

WVMI became interested in the vendor's Risk Prevention and Management (RPM) product in early 2001, and leadership especially appreciated the attention to the near miss: the event that has not yet caused harm but could. This focus provides opportunity for making

indicate trends about rural hospital care, about elderly care (we're especially interested in issues of polypharmacy) and about care to very poor populations.

One of the most important benefits WVMI sees is that real-time data-tracking can make everyone in the healthcare institution aware of the fact that their processes may not match their knowledge about best practices. The heightened awareness can lead to heightened involvement in improvement strategies.

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## Fear and Infrastructure

WVMI has encountered certain obstacles to getting the DoctorQuality program up and running, because it is a difficult proposition to change a culture from one that fears punitive action to one that pursues patient safety, even in the face of risk.

Hospital attorneys—rightfully so—are worried that the data gathered won't be kept confidential and might be subpoenaed. WVMI feels that its standing as a third-party, quality proponent gives it good influence in protecting hospitals that commit to patient safety.

In some areas, additional funding sources may be required for the implementation of hospital-wide computer systems. The good news is that once the computers and Internet connections are there, very little additional technology implementation is needed before patient safety improvements can occur.

A certain degree of marketing savvy must be leveraged to ensure hospitalwide use of the system. WVMI is encouraging participating hospitals to use promotion and reward mechanisms to drive the system's inclusion in the overall culture. For example, some hospitals have provided giveaways for employees who enter the highest number of errors or near misses in a given timeframe.

To date, WVMI has five hospitals on board with the RPM system, representing between 300 and 400 beds, and expects to sign on another 20 over the coming years.

The most important information we'll obtain and study will likely be in the near-miss category. We know healthcare institutions weren't tracking near misses in West Virginia.

Having knowledge doesn't necessarily mean the right treatment will take place. Healthcare administrators must stay vigilant for the gaps in care, pay attention to data from their individual institution, and provide the right strategy and processes for filling those gaps. When we ask ourselves what we might be missing, we find there is a world of

