Question 1:
You wrote about transformation of individual experts into expert teams. How can we as individuals and part of the health care team incentivize integration of expertise?

Response from Dr. Gluck:
On a global scale, the Patient Protection and Affordable Care Act (2010) will incentivize the formation of Accountable Care Organizations (ACOs) through payment reforms. First and foremost, ACOs seek to improve quality and reduce costs with a strong focus on primary preventative care. In order to achieve these goals, most ACOs will include medical professionals from various disciplines and skill levels—in essence, a team.

Our current educational system for medical professionals creates silos with physicians, nurses, pharmacists, and other medical providers seldom interacting with each other while they learn. As a first step, we must make medical education more multidisciplinary. For example, doctors, nurses, and pharmacists can all learn about medications together.

On a clinical level, it has been repeatedly shown that there is a significant increase in provider satisfaction working in a team environment.1 When individuals experience the benefits of team behaviors, it becomes self-perpetuating. Administrative leadership must embrace the value of team function to improve patient care. They must then incentivize all members of the health care team to undergo team training to begin the process.

Question 2:
Miscommunication, including incomplete handoffs and incomplete data reporting, is cited as one of the most common sources of error, particularly in obstetric care. What is your advice for correcting this?

Response from Dr. Gluck:
Handoff communication has become even more important with reduced resident work hours and obstetrician–gynecologists working in larger, more diverse groups. In one recent study of surgical malpractice claims related to poor communication, 43% involved poor handoffs.2

Handoffs are multifaceted, dynamic, and complex. Within each institution, there should be a standardized checklist for handoffs including at a minimum background, current clinical situation, assessment, pending diagnostics and procedures, and plans for treatment. However, a checklist to reduce the risk that some critical information will be overlooked,
though a good first step, is not sufficient to assure an ideal handoff. As much as possible, the handoff should be at a place and time that will minimize distractions and allow for discussion between the providers leaving and those assuming responsibility for the patient.

The handoff is even more challenging for patients going from the outpatient environment into the hospital, for example, in labor or with a pregnancy complication. Electronic medical record systems allow for efficient and timely transfer of prenatal records. Additionally, verbal communication with medical personnel assuming care of the patient is critical to allow for discussion and clarification of unresolved issues.

Question 3:

The concepts of quality and safety are integrally entwined, and yet both are hard to define except when they are absent. What scientific methods would you like to see incorporated into these evolving disciplines?

Response from Dr. Gluck:

The most difficult part of doing patient safety research is having reliable metrics to determine the effects of any intervention. There is no universally accepted standardized method to detect medical errors. This is further complicated by lack of transparency and disclosure of medical errors. Not all medical errors result in harm. Research should therefore focus on process errors and not necessarily bad outcomes.

Although not adequate by themselves, trigger tools offer the most effective way to evaluate care processes that may be flawed even if there is no patient harm. For a further discussion of trigger tools, see Question 5.

Question 4:

The identification of leaders who are open to system assessment instead of blaming and shaming is key to the evolution of a trustworthy and just culture. What system-wide approaches can be used to identify, educate, and empower future leaders?

Response from Dr. Gluck:

Transformational leaders can emerge from tragedy. This was the case at Dana-Farber Cancer Institute in Boston when the tragic death of Betsy Lehman led the Chief Operating Officer to examine their entire care delivery system. He subsequently became one of the strongest voices for system change to improve safety in Massachusetts and, later, nationally as Senior Fellow at the Institute for Healthcare Improvement.

A less traumatic path to patient safety leadership comes from observing the benefits of system-level changes for safety and continually building on them. Such was the case at Virginia Mason Hospital in Seattle. With strong support from the Board of Trustees, the hospital’s clinical leadership adapted the Toyota Production System to health care delivery, leading to dramatic improvement in outcomes, increased efficiency, and reduced costs.

Leaders are both a product of the prevailing culture and also transformers of the culture. For a culture of safety to thrive, there must be buy-in at the highest level of the organization—both by the Board of Trustees and the Chief Executive Officer. They must provide the resources to support patient safety initiatives. When there is willful violation of safety rules, they must be willing to support disciplinary measures up to and including dismissal from the medical staff.

The concepts of patient safety are simple compared to the complexity of clinical medicine. Future leaders can easily learn the basics of patient safety leadership through educational programs offered by the American College of Obstetricians and Gynecologists, the American College of Physician Executives, the Institute for Healthcare Improvement, and the National Patient Safety Foundation, among others.
Question 5:
Trigger tools such as no elective inductions before 39 weeks for the obstetric practice are well understood. Can you provide examples of similar tools that could be developed into general gynecologic practice?

Response from Dr. Gluck:
There are several trigger tools developed by the Institute for Healthcare Improvement that are applicable to gynecologic surgery. These include 1) readmission within 30 days of discharge, 2) health care–associated infection, 3) complications of a procedure resulting in injury to an organ such as bladder injury during hysterectomy, and 4) unplanned return to surgery.

Trigger tools have not yet been developed to evaluate potential errors in outpatient care. There are, however, some admitting diagnoses that might indicate errors in the outpatient environment and as such could serve as “triggers” to investigate system issues in the office or clinic. These diagnoses are known as “ambulatory care sensitive admissions.” An example would be admission for ruptured ectopic pregnancy. If women are compliant and receive good care, most, but not all, ectopic pregnancies can be diagnosed before rupture.

Question 6:
Inadvertent errors that are met with blame and punishment prevent transparency and establishment of the just culture. Inadvertent errors, preventable adverse events, and near misses can teach us all but must be disclosed in a way that promotes acceptance and education. How would you tailor such disclosures while protecting patients from harm, mitigating frivolous legal incursions by plaintiff attorneys, and yet maximizing education of physicians at all levels, nurses at all levels, medical students, laboratory personnel, and support staff?

Response from Dr. Gluck:
Transparency, with disclosure of adverse events, is critical to help inform system changes that will reduce errors. Furthermore, it is our ethical responsibility to inform patients if they have suffered harm from medical error. When done properly, an empathetic and honest disclosure of an adverse event will help maintain physician patient rapport, will help reduce physician guilt, and has been shown to reduce litigation exposure and costs. Most providers are not trained for and are not comfortable having these difficult conversations. Learning how to disclose adverse events should be part of medical education. Residents should be able to observe and potentially participate in disclosure conferences.

A just culture is essential in promoting transparency. Individuals cannot be blamed for inadvertent errors. Although each case is different, there are some basic principles for disclosing medical errors that result in harm. First, the patient’s immediate medical needs must be addressed. Once medically stable, the attending physician should lead the discussion along with other members of the health care team determined by the circumstances of the case. The hospital may have a policy regarding the presence of a risk manager and others during the discussion. It should be timely and should only disclose what is known without speculation or attribution of blame. The decision about the presence of other family members and friends should be left up to the patient. The disclosure should be in a quiet location, away from other patients and other providers. It is important for the providers to express empathy acknowledging the emotional and physical effect of the error on the patient and her family. Arrangements should be made for follow up discussions once more information becomes known or to answer additional questions by the patient.

Question 7:
What would you suggest to foster use of Institute for Healthcare Improvement Surgical Trigger Tool, Agency for Healthcare Research and Quality TeamSTEPPS, or other standards for defining safety tools?
Response from Dr. Gluck:

There are many tools available that may help improve patient safety and reduce patient harm. There is no single intervention that can be universally implemented by every institution. Tools may need to be modified based on local resources. An essential first step for successful implementation of any tool is establishing a culture of patient safety. For example, part of the TeamSTEPPS program is a patient safety culture assessment survey to be sure that the environment is ready to support team training.

A safe culture will only happen if there are enlightened clinical and administrative leaders (see Question 4). When this culture is established, many safety interventions can be implemented and sustained. Some safety tools may be easy to initiate, such as trigger tools to detect potential medical errors. More difficult may be the use of checklists to promote communication and standardization. Among the most difficult components of safety programs is establishing well-functioning teams. It will be up to the leadership to prioritize the various safety interventions and then commit the necessary human and financial resources to help make it happen.

Question 8:

Institutions respond best to change that has been shown to be cost-effective. Team building without simulation has been found to be less robust. How can we convince hospitals that team building with simulation defines safer work environment for all concerned—patient, family and staff—when hospitals and health systems choose to ignore data supporting simulation reinforced training?

Response from Dr. Gluck:

Demonstrating a return on investment from any patient safety intervention, including simulation to promote team training, remains a barrier in many institutions. Team training has been shown to improve employee satisfaction and thereby increase staff and especially nurse retention. There are significant costs related to recruitment and training of new nurses. Reductions in cost to treat medical errors and mitigate lawsuits are additional financial arguments that favor patient safety programs. Finally, standardization, an important patient safety strategy, will help improve supply chain management. This is most apparent for medical equipment and pharmacy costs.

References:


Further Reading:


