

February 2011

*A Conversation With Bill Walsh*

# PATIENT SAFETY UPDATE

*We have established an organizational culture in which  
the safety of our patients is our number one commitment.  
Patients and their families must be able  
to count on that commitment, from each one of us.  
They certainly deserve no less.*



JACOBI MEDICAL CENTER  
NORTH CENTRAL BRONX HOSPITAL

## *A Conversation with Bill Walsh*

# PATIENT SAFETY UPDATE

Fostering informed, engaged employees who understand and identify with our mission is a key aspect of our ability to provide safe, high quality care.

This publication helps achieve that goal and more by communicating important information about organizational services and strategic initiatives, and showcasing our staff to employees at every level of the North Bronx Healthcare Network and the general public.



### Has the problem of medical errors always been such an important cause for concern?

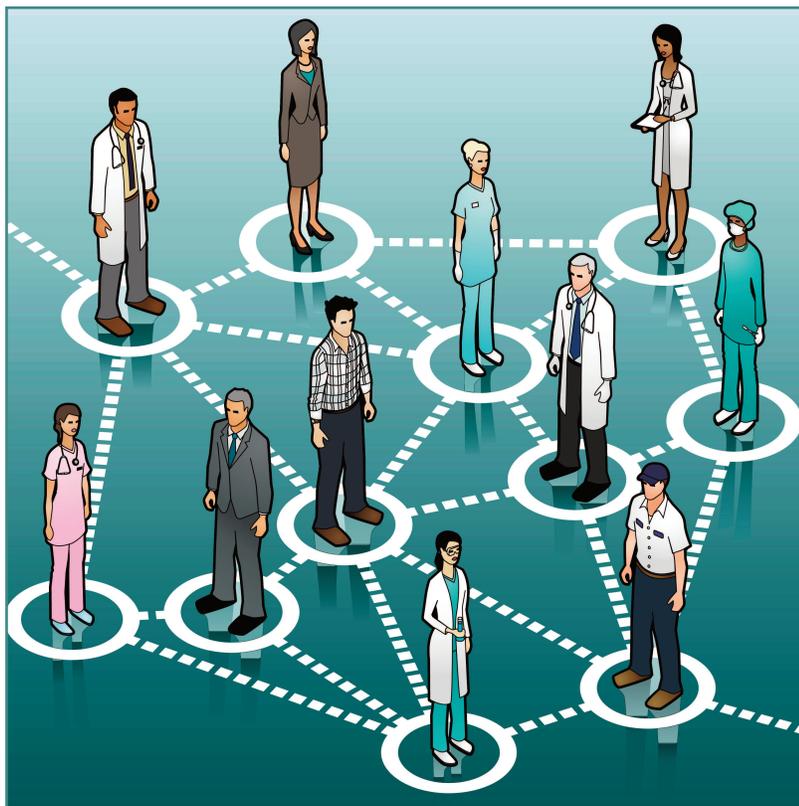
The problem had not received as much attention as it deserved until a little more than 10 years ago, when the Institute of Medicine's bombshell report, *To Err is Human*, incensed the American public with disturbing details about medical harm in US hospitals. The report estimated that somewhere between 44,000 and 98,000 people die every year because of medical mistakes that should never have occurred. In addition to loss of life, errors were blamed for billions of dollars in health care costs, lost income, disability compensation, and the like.

### Did the Institute of Medicine (IOM) report identify any culprits?

The report placed blame squarely on faulty systems and processes that lead people to unwittingly make the mistakes that harm patients. Systems that produce inadequate, fragmented, or illegible medical record keeping. Systems that encourage miscommunication among providers. Systems that create confusion over drugs which look alike, sound alike, or are otherwise poorly labeled. Systems that cause delays in diagnosis or treatment due to untimely or inadequate reporting of key testing results. These are all examples of systems which set the stage for failure, so that even the best trained provider can make mistakes.

### What was done following the report, to improve safety?

Since the report, there has been an enormous effort at multiple levels, to find ways in which we can provide and insure safer care. Governmental agencies such as the Agency for Healthcare Research and Quality (AHRQ), patient safety organizations such as the Joint Commission and the Institute for Healthcare Improvement (IHI), business groups like the Northeast Business Group on Health, market-driven coalitions such as the Leapfrog Group, and independent monitoring advocates like Consumers Union – these all exercise powerful influence in our mission to find enduring ways to deliver consistently safer care.



## Can you give some examples of how care was improved?

Initiatives too numerous to mention have been put into place. They include things like the establishment of electronic health records with computerized physician order entry systems, the creation of both mandatory and voluntary error reporting systems, FDA pre-market testing of drugs for name confusion, adoption of standardized, evidence-based treatment protocols with outcome measurement, and insurer no-pay policies for preventable events like hospital-acquired infections, are just a few of them.

## So a lot has been accomplished since the IOM report to help insure safer care. But what do you think? Is care truly safer?

In certain ways it is. But the jury's still out on a definitive answer to your question, and I must say the indications so far aren't great. The AHRQ itself estimates that overall, patient safety has actually declined, not improved, since the IOM findings. And there are a couple of recent reports which indicate that as a country, we are not seeing the kind of results that are needed to say that we have made any real impact.



### INITIATIVES THAT HAVE IMPROVED CARE

THE ESTABLISHMENT OF ELECTRONIC HEALTH RECORDS WITH COMPUTERIZED PHYSICIAN ORDER ENTRY SYSTEMS

THE CREATION OF BOTH MANDATORY AND VOLUNTARY ERROR REPORTING SYSTEMS

FDA PRE-MARKET TESTING OF DRUGS FOR NAME CONFUSION

ADOPTION OF STANDARDIZED, EVIDENCE-BASED TREATMENT PROTOCOLS WITH OUTCOME MEASUREMENT

INSURER NO-PAY POLICIES FOR PREVENTABLE EVENTS LIKE HOSPITAL-ACQUIRED INFECTIONS

## To Err is Human – To Delay is Deadly

Ten years later, a million lives lost, billions of dollars wasted

**ConsumersUnion.org**

Nonprofit Publisher of Consumer Reports

Really! And after all that effort? What are the new reports telling us?

In May of 2009, Consumers Union (the publisher of Consumer Reports) released its own assessment at the 10-year anniversary of the IOM recommendations. They called it *To Err is Human – To Delay is Deadly*. While they acknowledge that considerable effort has been made, overall they view that effort as fragmented and inadequate, voluntary and unacceptable. The report points out that too few hospitals have adopted systems proven to prevent medication errors, there is as of yet no national, mandated and public error reporting system, there is no national entity which has the power to effectively coordinate and monitor improvements, and there is no national oversight to monitor and ensure provider competency.

Even more recently, the New England Journal of Medicine just released the results of a study conducted at 10 hospitals in N. Carolina. This study of more than 2,300 hospitalized Medicare patients found that 18% were harmed by medical care. Some experienced multiple harms. 63% of the injuries were considered preventable. Most of the injuries caused problems that were temporary and treatable, but not all: 2.4% of them contributed to the patient's death.

## The commitment is to change our culture as an organization by placing *patient safety at the top of our agenda.*

**Well these results don't sound too encouraging, at least at the national level. But let's talk about what's happening here at home. How do you think our hospitals are doing in making patient safety improvements?**

As a Network, we have made lots of progress in providing safer care. Many of these are technology-driven. For example, physician order entries are fully automated, and electronic flags for contraindications in medication ordering help providers to avoid errors in use or dosage of drugs. Electronic systems enable test reporting that is nearly instantaneous. In the outpatient department, tracking of diabetic patients through on-line Registries shows us that we have increased the number of patients whose HbA1c is under 7 by 50%.

**So you think the answer is better technology?**

It's not that simple. Technology is only one aspect of a much bigger commitment. The commitment is to change our culture as an organization by placing patient safety at the top of our agenda.

**How do you go about changing a culture?**

By applying strategies which imbed the importance of safe care deeply into every level of the organization. So what are those strategies? Well, one of the first things we did was to teach hospital leadership how to utilize a powerful risk reduction strategy called a Failure Mode Effect and Criticality Analysis, or FMECA. This method calls for a scrupulous analysis of every step performed in a process that could have serious consequences. The idea is to identify which of the steps in the process has the potential for failure, which would contribute to a bad outcome. Once you know where the potential for failure is, you can figure out how to fix it, so as to prevent a failure from occurring. Every service line and hospital department does at least two of these analyses a year. By choosing the right processes to analyze and strengthen, you become over time, a safer organization overall.

We also perform regular Patient Safety Walk Rounds on patient units, and we do so with the front line staff who works on the unit. Together, we identify safety issues, and we encourage staff to share their ideas on how to fix them.



*Patient Safety Walk Rounds (12/10)*

LEAN principles rely heavily on two important concepts which are key to building a culture of safety within an organization.

## One is respect for people.

*The other is the idea of continuous improvement of work processes.*

LEAN *Increase Efficiency ❖ Eliminate Errors ❖ Enhance Patient Safety ❖ Improve Patient Satisfaction*



And finally, three years ago we adopted LEAN as our organization's improvement methodology. LEAN principles rely heavily on two important concepts which are key to building a culture of safety within an organization. One is respect for people. The other is the idea of continuous improvement of work processes. LEAN has already produced many significant patient safety improvements. One good example comes from the Imaging Value Stream. By focusing on the appropriateness of CT orders, we have created a process that significantly reduces patient exposure to radiation.

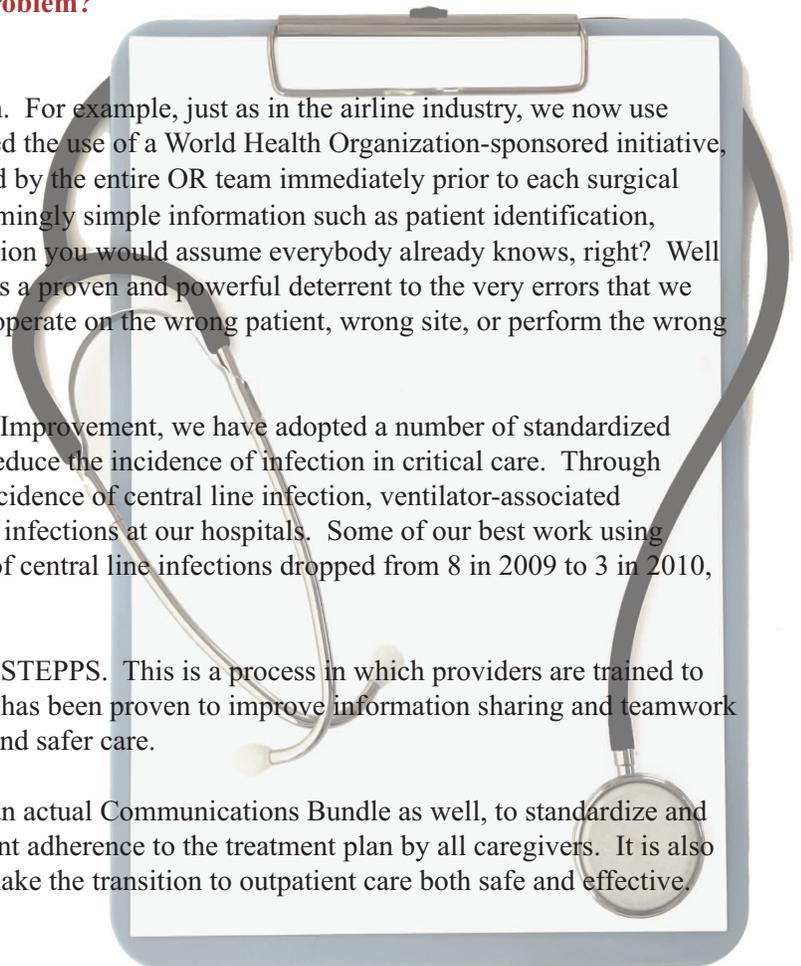
### **The recent reports you mentioned earlier talk a lot about errors arising from poor communication. Have we addressed this problem?**

We have done a lot of work on improving communication. For example, just as in the airline industry, we now use checklists in many of our procedures. We have established the use of a World Health Organization-sponsored initiative, called the **Pre-op Checklist**. The checklist is completed by the entire OR team immediately prior to each surgical procedure. Among other things, the checklist insures seemingly simple information such as patient identification, surgical side and site, bleeding precautions, etc. Information you would assume everybody already knows, right? Well as a matter of fact, it's not always known. The checklist is a proven and powerful deterrent to the very errors that we have all heard about in the news, such as when surgeons operate on the wrong patient, wrong site, or perform the wrong procedure.

Through our partnership with the Institute for Healthcare Improvement, we have adopted a number of standardized treatment protocols called bundles, which are proven to reduce the incidence of infection in critical care. Through consistent use, these bundles have steadily reduced the incidence of central line infection, ventilator-associated pneumonias (VAPs), and catheter-associated urinary tract infections at our hospitals. Some of our best work using bundles is demonstrated in the SICU, where the number of central line infections dropped from 8 in 2009 to 3 in 2010, and VAPs dropped from 13 to 6.

We have also trained many of our staff in the use of TeamSTEPPS. This is a process in which providers are trained to use standardized communication within the care team. It has been proven to improve information sharing and teamwork skills, and those improvements help us to provide better and safer care.

The Department of Medicine is working on establishing an actual Communications Bundle as well, to standardize and document the information necessary for safe and consistent adherence to the treatment plan by all caregivers. It is also working on modifications to the discharge summary, to make the transition to outpatient care both safe and effective.



**HHC is one of the first systems in the country to voluntarily report on several quality and performance indicators for each of its facilities. The data is called HHC in Focus, and it's all posted right on the HHC website.**

**What about the issue of error reporting? The Consumers Union assessment stated that without it, the public is kept in the dark about hospital-specific performance.**

Unfortunately, reporting of this kind of information is inconsistent from state to state, as well as from institution to institution. But even in the absence of clear and consistent disclosure mandates, the HHC is one of the first systems in the country to voluntarily report on several quality and performance indicators for each of its facilities. The data is called HHC in Focus, and it's all posted right on the HHC website. Voluntarily publishing this information keeps us both transparent and accountable. And it helps people to make more informed choices about their healthcare providers.

### **So where do we go from here?**

While we all acknowledge that we have a long road ahead of us, I am very proud of the progress our institutions have already made. And by the way, our progress has earned some public acknowledgement. In November 2010, Jacobi earned the Most Improved Performance in Patient Safety and Quality Award from the NY Business Group on Health-Leapfrog Group. By taking the greatest advantage of what technology has to offer, by incorporating proven, evidence-based practices into our treatment protocols, by standardizing methods, optimizing teamwork, and using LEAN to improve work processes, we have established an organizational culture in which the safety of our patients is our number one commitment. Patients and their families must be able to count on that commitment, from each one of us. They certainly deserve no less.

*Jacobi Medical Center Awarded  
The Most Improved Performance in  
Patient Safety and Quality Award  
from the NY Business Group on  
Health-Leapfrog Group  
- November 2010 -*

*“The Leapfrog Group rates hospitals  
on the national level on their  
quality and safety—and we set a very high bar.  
Jacobi Medical Center  
shows they welcome that challenge—and  
the people of New York City should  
be proud of their accomplishments.*

*- Leah Binder, CEO, The Leapfrog Group*



### **THE NORTH BRONX HEALTHCARE NETWORK**

**WILLIAM P. WALSH, SENIOR VICE PRESIDENT**

Jacobi Medical Center 1400 Pelham Parkway South ♦ Bronx, NY 10461 ♦ (718) 918-5700  
North Central Bronx Hospital 3424 Kossuth Avenue ♦ Bronx, NY 10467 ♦ (718) 519-5700  
HHC - NYC Health & Hospitals Corporation [nyc.gov/hhc](http://nyc.gov/hhc)

*A Conversation With Bill Walsh is produced by the Department of Public Relations, NBHN*