

# Medication Safety Issue Brief

## *Creating a Culture of Safety*

1

of 6 in a series

Part one of this six-part series is designed to help senior management take concrete steps to reduce errors in their hospitals. The American Hospital Association, the American Society of Health-System Pharmacists and *Hospitals & Health Networks* jointly developed this project with the generous support of McKessonHBOC. Tear out this card for future reference. Additional copies are available in PDF format on the ASHP and *H&HN* Web sites ([www.ashp.org](http://www.ashp.org) and [www.hhnmag.com](http://www.hhnmag.com)). ASHP members can also call the ASHP's fax on demand service.

### ● SUMMARY

Health care won't be safer until mistakes are seen as the result of multiple factors, not simply one person's misstep. A culture of safety produces an environment where practitioners and senior leaders can learn together about how to create safer systems of care. This requires a philosophy that safety is everyone's business, and an environment in which staff members feel it is safe to report a problem so the system can be changed to prevent a recurrence. This briefing examines what hospital executives can do to create a culture of safety.

### ● ISSUE BRIEF

Doctors, nurses and pharmacists may work at the front lines of safeguarding against medical errors, but the systemic changes needed to determine the root causes must come from the top. Some hospital executives have found that personal involvement has been key in helping to create a culture of safety within their institutions. That means educating the board of trustees on the issue, making a significant place for patient safety initiatives in the budget, or making personal phone calls to those involved in an error.

"When you head an organization you set the environment for the right things to happen," says Gordon Sprenger, president and CEO of Allina Health System in Minneapolis. "The organization watches the CEO very closely. You have to tell people that this is important, and I think every CEO has their own way of doing that."

Sprenger's style is to get personally involved by phoning the staff involved in an error and providing support along with impetus to get to the root cause of the problem. "It is without a doubt the single most powerful symbolic action you can take as the CEO to move patient safety toward the top of the list for people with hundreds of compelling demands," he says.

For administrators and trustees who must balance the needs of the hospital with unprecedented financial pressures, it is useful to understand medication safety as a business issue as well as an ethical one. "The use of unnecessary resources to redo work, pay for extra procedures or increase length of stay, or pay significant claims due to harm that we have brought to patients, cannot and should not be tolerated," Sprenger says.

He worked closely with the legal and risk management staffs to find ways to be more open with patients and families when something goes wrong. They developed a "legally safe" newsletter to share alerts, warnings, near-misses and successes among all the system's hospitals and clinics.

Sprenger has found that those delivering care have long been aware of systemic prob-



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## ACTION Agenda

Here is a list of action items you can use to create a culture of safety within your organization:

- Take a personal interest when something goes wrong. Talk to the patient and family, as well as the health care professionals involved. Attend the follow-up staff sessions examining what happened, and support changes that need to be made to systems.
- Establish a non-punitive atmosphere. Consider eliminating systems that penalize employees for making mistakes that can be traced to system problems.
- Educate your board of trustees about the systems approach to reducing medication errors.
- Make patient safety one of the organization's top strategic goals.
- Produce an economic analysis of the cost of an error in your organization, and make a place for medication safety initiatives in your budget.
- Establish a "team" approach that allows all levels of caregivers an equal opportunity to speak out to prevent an error.
- Invite a human factors consultant to observe a patient care unit or a patient care process.
- Investigate options for automating medication prescribing and delivery, and follow up to ensure that the automation doesn't add complexity and potential for mistakes.
- Work with labor representatives on discipline policies.
- Don't ignore the near-misses. Ensure that they are taken as seriously as errors that cause actual harm. They can be an effective early warning system.
- Recognize that once you reduce barriers to error reporting, the numbers will look worse before they get better. Be prepared to explain that to trustees and the public.

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lems that make errors possible. "They don't need to be convinced of the importance of a renewed emphasis on preventing medication errors," he says. "It's those of us who are removed from caregiving who aren't aware of how serious this is."

To that end, Allina held patient safety culture workshops for all senior officers of the organization to move away from denial and place error reduction on the front burner.

He urges hospital executives to make medical safety a priority, and stay on top of it. "This is something you really need to have a fire in your belly over."

### ● CASE STUDIES

**Dana-Farber Cancer Institute, Boston, Mass.:** Dana-Farber learned the hard way how costly a medical mistake can be when a high-profile patient died and another was injured by overdoses of chemotherapy drugs. The 1994 incidents prompted major changes in the way medications are administered, along with a shift toward a "systems" approach in examining errors. For instance, the hospital installed an electronic order entry system with a computerized backup that compares the drug order with pre-programmed guidelines. That system is backed up with checks by nurses and pharmacists. Also, the organization no longer penalizes staff members for mistakes, prompting a big jump in reporting.

Chief operations officer James Conway recommends working closely with the hospital board of trustees to make these changes. For instance, Conway suggests, reserve time for a discussion of quality, safety and risk at each board meeting, and organize at least one board meeting per year as an intense examination of patient safety. When an incident occurs, hold a staff-level meeting immediately to review what happened, and be sure management participates.

**Veterans Health Administration:** The largest health system in the nation has made patient safety a priority and has led the industry in innovations. Most recently, the VHA announced it had created, with the help of the National Aeronautics and Space Administration, an external voluntary reporting system that allows physicians, nurses, pharmacists, laboratory personnel and others to report unsafe occurrences without fear of action being taken against them.

James Bagian, a physician and former astronaut, heads the VHA's patient safety center and describes some of the other ways the giant organization is addressing the issue:

- A reward system, offering up to \$5,000, for identifying errors, potential errors or a solution to prevent them.
- Systemwide bar coding for all blood transfusions.
- A target of having 30 percent of all deaths autopsied.
- Examination of all close calls.
- Surveying employees for their views of the organization's culture of safety.

