PATIENT SAFETY AND HOSPITAL ACCREDITATION
A Model for Ensuring Success

Sharon Ann Myers

SPRINGER PUBLISHING COMPANY
Patient Safety and Hospital Accreditation
Sharon Myers, RN, MSN, MSB, FACHE, CPHQ, CHCQM, CPHRM, graduated from Johns Hopkins University School of Nursing, with both a master of science in nursing health systems management and a master of science in business.

She is currently the quality management officer for the VA MidSouth Healthcare Network (VISN 9) in Nashville where she provides oversight to six health care facilities, ensuring utilization management, continuous survey readiness, systems redesign, and data-management activities, support high-quality patient care and is an adjunct associate nursing professor at Vanderbilt University School of Nursing.

Prior to her VA career, Myers worked as the director of quality management at the King Abdulaziz Medical City in Saudi Arabia and successfully led that facility through its first Joint Commission accreditation. She also served as senior consultant to the Makkah Region Quality Program and the Central Board of Accreditation of Healthcare Institutions in Saudi Arabia, where she assisted in the development of the first Hospital Standards Manual which was approved by the Ministry of Health for implementation. Subsequently, she assisted Central Board of Accreditation for Healthcare Institutions (CBAHI) in developing their national survey process. She was the assistant director of nursing at Johns Hopkins Bayview Care Center in Baltimore, where she led nursing groups to develop a career ladder for nursing assistants in long-term care which won an “innovations in nursing practice” award. In addition to the quality-improvement positions she held in Saudi Arabia, she has also been a nursing education coordinator, clinical educator, and nursing supervisor. She has owned an independent consulting firm which developed curriculum for cross-training medical–surgical nurses for critical care and developed self-learning modules approved by the Florida State Board. She served as a Captain in the U.S. Air Force, serving three tours of duty, one of which was overseas.

She is a recognized international speaker on indicators and measurement, quality concepts, and patient safety. In addition, she has been a guest lecturer at Johns Hopkins School of Nursing and at King Abdulaziz University in Saudi Arabia.

She holds numerous national certifications and memberships in health care management, quality management, and risk management. She has authored many instructional articles, and is a published author in the fields of accreditation and patient safety.

When not on travel, Myers resides outside of Nashville, Tennessee, with her husband, John.
Patient Safety and Hospital Accreditation

A Model for Ensuring Success

Sharon Ann Myers, RN, MSN, MSB, FACHE, CPHQ, CHCQM, CPHRM
Copyright © 2012 Springer Publishing Company, LLC

All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior permission of Springer Publishing Company, LLC, or authorization through payment of the appropriate fees to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400, fax 978-646-8600, info@copyright.com or on the Web at www.copyright.com.

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Allan Graubard
Production Editor: Michael Lisk
Composition: S4Carlisle Publishing Services
ISBN: 978-0-8261-0639-1
11 12 13/ 5 4 3 2 1

The author and the publisher of this Work have made every effort to use sources believed to be reliable to provide information that is accurate and compatible with the standards generally accepted at the time of publication. The author and publisher shall not be liable for any special, consequential, or exemplary damages resulting, in whole or in part, from the readers’ use of, or reliance on, the information contained in this book. The publisher has no responsibility for the persistence or accuracy of URLs for external or third-party Internet Web sites referred to in this publication and does not guarantee that any content on such Web sites is, or will remain, accurate or appropriate.

Library of Congress Cataloging-in-Publication Data
Myers, Sharon.
p. ; cm.
Includes bibliographical references.
ISBN 978-0-8261-0639-1
I. Title.
LC classification not assigned
362.11028’9—dc23
2011038875

Special discounts on bulk quantities of our books are available to corporations, professional associations, pharmaceutical companies, health care organizations, and other qualifying groups.

If you are interested in a custom book, including chapters from more than one of our titles, we can provide that service as well.

For details, please contact:
Special Sales Department, Springer Publishing Company, LLC
11 West 42nd Street, 15thFloor, New York, NY 10036-8002s
Phone: 877-687-7476 or 212-431-4370; Fax: 212-941-7842
Email: sales@springerpub.com

Printed in the United States of America by Gasch Printing
This book is dedicated to my husband, John, who has supported my professional and personal goals for the past 30 years. He has encouraged me to think outside of the conventional boxes, to not accept what is, but to strive for “what should be” to make health care trustworthy for our patients and staff.
Contents

Preface        ix

SECTION I: OVERVIEW OF HOSPITAL ACCREDITATION AND PATIENT SAFETY
1. Introduction to Concepts of Hospital Accreditation and Patient Safety    3
2. Milestones of Hospital Accreditation and Patient Safety in the United States   19
3. A Global View of Patient Safety and Accreditation                      39

SECTION II: WHY A MODEL IS NEEDED WHEN DEVELOPING AND IMPLEMENTING PATIENT SAFETY AND ACCREDITATION INITIATIVES
5. Current Challenges in Health Care                                    75
6. The Reliability Factor and Why Adverse Events Still Happen in Accredited Health Care Organizations  83
7. Organizational Architecture in Relation to Accreditation and Patient Safety Efforts: Ready, Fire, Aim  99

SECTION III: THE MYERS MODEL FOR PATIENT SAFETY AND ACCREDITATION
8. Overview of the Myers Model for Patient Safety and Accreditation and Its Application in Health Care  129
9. Design at the Leadership Level (System Level)                         155
10. Design at the Unit Level (Microsystem)                               183
11. Design at the Individual Level                                       221
SECTION IV: TOOLS FOR BUILDING A BETTER REPORTING SYSTEM
12. How the Model Assists Nursing With Accreditation and Patient Safety Efforts  241
13. Measurements and Data Integration  249
14. Root Cause Analysis and Failure Mode and Effects Analysis  265

SECTION V: RECOMMENDATIONS FOR FUTURE CONSIDERATION
15. Recommendations for Accrediting Bodies and Health Care Organizations  283

Appendix B Strategies and Tips for Maximizing Failure Mode & Effect Analysis in Your Organization  297

Index  309
Preface

First do no harm. It has been more than 10 years since the Institute of Medicine’s report To Err is Human: Building a Safer Health System was published and patient safety became a priority in the United States and internationally.

The goal of this book is to provide a model for consideration when leading patient safety and accreditation initiatives. The Myers Model for Patient Safety and Accreditation is the first time that current evidence has been presented within a model that assists strategic planning to sustain or to gain accreditation with high levels of patient safety.

There are five sections in this book. Section I covers the key concepts related to hospital accreditation and patient safety, important milestones of each, then branches out into the global view. Interviews with three major leaders of health care accreditation programs are included: Joint Commission, Accreditation Canada, and the Australian Council on Healthcare Standards (ACHS). Each leader shared their views on key aspects of patient safety in relation to their own accreditation program. Joint Commission’s leader, Dr. Paul Schyve, senior vice president, discussed the Hand Hygiene Project at the Center for Transforming Healthcare (subsidiary of the Joint Commission). He also spoke about how the Patient Safety Advisory Group is tackling issues such as worker fatigue. Wendy Nicklin, president and CEO of Accreditation Canada, discussed standards that measure the Quality of WorkLife. Accreditation Canada administers a Worklife Pulse Survey every 3 years as part of the accreditation process. In Canada, a positive worklife culture is considered a strategic priority. Brian W. Johnston, chief executive of the ACHS, discussed how they use an internationally recognized Evaluation and Quality Improvement Program (EQuIP) that encourages progressively higher standards of performance through a 4-year EQuIP cycle. ACHS has a number of indicator sets that are specialty specific that measure adverse events.
Section II sets up the foundation of why a model is needed when implementing patient safety and accreditation programs. This section covers some of the current challenges in health care with emphasis on concepts of reliability that are related to patient safety. Outdated organizational architecture is discussed along with various structures that may enhance work at the unit (microsystem) level. Finally, a general overview of the *Myers Model for Patient Safety and Accreditation* is presented. The model presents a systems approach that should be used when initiating patient safety and/or accreditation initiatives. Every element within the model is interrelated with the other components. The three levels of organizational architecture are presented: design at the leadership level (system), the unit level (microsystem), and the individual level. All three levels must be aligned with the other elements within the model to achieve the aims of the system.

Section III presents the three levels in detail with current evidence for each level. There is great emphasis placed on design at the leadership level. If the leadership is dysfunctional, it will negatively affect all of the other elements in the model and make it difficult, if not impossible, to achieve the aims of the system. Design at the unit (microsystem) level is aligned with the other elements within the model, and current research is presented for evaluation when developing and maintaining effective outcomes. Design at the individual level is aligned with all the other elements within the model, including nursing leadership, making it clear how the *Myers Model for Patient Safety and Accreditation* assists in creating and sustaining an enriched environment of professional practice that ensures engagement of nursing staff.

Section IV provides an overview of reporting systems within the United States and covers two essential tools that are used to ensure patient safety: root-cause analysis and failure mode and effects analysis.

The last section contains recommendations for consideration to accrediting bodies and to health care organizations, which may enhance their patient safety and accreditation efforts. This section summarizes previous material presented and reinforces the new aims statement. *ZERO is the number and NOW is the time.* “No preventable harm to patients or staff” is the goal for high–reliability health care organizations and the time to start working toward that goal is NOW.
Overview of Hospital Accreditation and Patient Safety
Introduction to Concepts of Hospital Accreditation and Patient Safety

OVERVIEW

When patients are admitted to the hospital, they put their trust in health care professionals to do the right thing, on time, all of the time. Health care systems that are accredited demonstrate to the public that they have maintained compliance with a set of standards that provides the public at least some reassurance that quality and patient safety standards are being met. Unfortunately, even in accredited health care organizations, patients are harmed by medical errors every day.

Accreditation is increasingly being utilized as a key driver for implementation of patient safety efforts to reduce patient harm caused by medical errors.

There are many definitions of accreditation; however, there is a general consensus on the following key concepts:

- Accreditation is usually a voluntary process.
- Accreditation’s evaluation process is external.
- Accreditation involves the use of dynamic standards organized into three domains.
- Accreditation’s standards have the potential to achieve optimum performance.
Accreditation Is Usually a Voluntary Process

Accreditation for health care organizations is seen as a voluntary or legal requirement in many countries. In the United States, accreditation programs are voluntary and must be approved by the Centers for Medicare and Medicaid Services (CMS) programs for the health care organization to participate in and receive payment from the Medicare or Medicaid program. CMS may grant the accrediting organization “deeming” authority, in which case, the health care organization would not be subject to Medicare’s routine survey and certification process.

Accreditation’s Evaluation Process Is External

The fact that the evaluation process is external to the organization ensures greater objectivity than if the evaluation were internal.

Having outsiders with no relationship to the health care organization assess the level of performance according to an agreed-on set of standards is critical for accreditation.

The surveyors are health care professionals carefully selected for their subject matter expertise. This becomes a form of external peer review when the surveyors are matched to clinical and nonclinical areas according to their expertise.

The Accreditation Process Involves Standards

Standards are developed through a consensus process and peer review. Professional organizations, various stakeholder groups, and expert panels are all used in writing standards in which the expected performance is measured in the accreditation process by survey methods.

Standards Are Dynamic and Are Organized Into Three Domains

Standards are not static. They are continually revised as new knowledge emerges. Health care standards are organized into the three domains of structure, process, and outcome based on Donabedian’s model (Donabedian, 1988).

Increasingly, patient safety standards are being integrated into the Joint Commission accreditation requirements. According to the Joint Commission (2010), almost 50 percent of their standards are directly related to patient safety.
Concepts of Hospital Accreditation and Patient Safety

Accreditation organizations encourage health care organizations to achieve optimal standards through the application of continuous quality improvement (CQI) concepts. Through the application of CQI concepts, an organization is able to progress from its existing level of performance to the optimal level of standards compliance (see Figure 1.1).

Ten years ago, optimal level of achievement looked very different than it does today. For example, accepted thresholds for hospital-acquired infections for central line–associated bloodstream infections were set before any improvement project was initiated. There was a general complacency and acceptance that many adverse events were related to complications beyond the provider’s control.

Expectations are different now. For example, there is the implementation across the United States of the Institute for Healthcare Improvement’s (IHI’s) 5 Million Lives Campaign. Here, through consistent implementation of the central line bundles, central line–related infections have been dramatically reduced to zero.

**PATIENT SAFETY DEFINED**

Errors that result in patient injury are sometimes called preventable adverse events, which means that the injury resulted from a medical intervention and not the patient’s underlying disease state. An example
of a preventable adverse event is if a patient were to receive 10 times the normal dose of an anticoagulant resulting in death.

The Agency for Healthcare Research and Quality (AHRQ) describes patient safety as “freedom from accidental or preventable injuries produced by medical care” (AHRQ, n.d.-a). Health care organizations are expected to provide safe care and do no harm. Luckily, all medical errors do not result in preventable adverse events, either through chance or timely intervention.

An example of a medical error in which no harm occurred because of chance is when the patient receives the wrong diagnostic test because of misidentification; however, no harm occurred because the diagnostic test (by chance) was noninvasive with minimal risk.

An example of no harm occurring because of timely intervention is when a nurse administers double the dosage of a narcotic, which depresses respirations of a patient; however, she recognizes her error and the patient receives timely intervention through administration of Narcan, which reverses the narcotic effects quickly.

COMMON THEMES OF PATIENT SAFETY

Patient safety concepts involve culture, communication, high-reliability organizations (HROs), systems thinking, human factors, reliability, evidence-based medicine, reporting systems, and use of tools such as failure modes, effects analysis, and root cause analysis (RCA). All of these concepts reside under the umbrella of CQI and continuous and consistent leadership.

Culture

Improving the culture of safety is an essential component of preventing or reducing errors as well as improving overall health care quality.

Unfortunately, even though culture is an essential component for patient safety, the AHRQ has reported wide variation in patient safety cultures in hospitals across the United States.

According to the IHI (n.d.-a), “In a culture of safety, people are not merely encouraged to work toward change; they take action when it is needed.”

The AHRQ (n.d.-b) states that the culture of patient safety comprises the following key features:
There is acknowledgment of the high-risk nature of an organization’s activities and the determination to achieve consistently safe operations. Health care organizations now acknowledge that providing care to patients is risky and are increasingly becoming determined to achieve higher degrees of safety.

There is a blame-free environment and individuals are able to report errors or near misses without fear of reprimand or punishment. The term blame-free was misunderstood initially to mean that no person would be accountable for his or her actions. The term used now is just culture (as in a “culture of justice”), where reckless behavior is not tolerated; however, no one is punished for making an honest mistake.

There is encouragement for collaboration across ranks and disciplines to seek solutions to patient safety problems.

In hospitals, collaboration is challenging because of conflicting cultures, politics, and organizational architectures.

The organization commits resources to address safety concerns. Hospitals have shrinking budgets and numerous competing demands for money expenditures, which is especially challenging when expensive capital expenditures are required.

There is an increasing interest in measuring patient safety culture within health care organizations, and accrediting bodies such as Joint Commission are including patient safety culture as a requirement for measurement and improvement.

Communication

Communication deficiencies in large complex systems are one of the primary contributing causes for medical errors.

The Controlled Risk Insurance Company of Vermont (CRICO/RMF), the patient and medical malpractice company that has served the Harvard medical community since 1976, states that medical errors can occur when individuals from different backgrounds or health care disciplines have different communication styles that the organization does not accommodate.

CRICO further states that role conflict or confusion occurs when any member of a health care team is uncertain about the specific role he or she is expected to fill, or when he or she is confused about the
role and responsibilities of other team members. Role confusion results in communication problems, which can lead to medical errors.

There are many communication interventions for health care systems that assist in building a safer environment for patient care (CRICO/ RMF, n.d.).

Some examples include Crew Resource Management (CRM), which was adopted from the aviation industry in 1979. The concept was used in the aviation industry to address the role that human errors played in airplane crashes to achieve flights that were safe and effective.

CRM involves team training on the limitations of human performance. Staff are taught about cognitive errors and the influence that stressors such as fatigue, work overload, and emergent situations can have on the frequency of errors. Staff are taught to speak up using inquiry and advocacy methods and communication techniques, including conflict resolution (Pizza, Goldfarb, & Nash, 2001).

IHI (n.d.-b) presented the Situation-Background, Assessment-Recommendation (SBAR) as another technique for communication between members of the health care team. This involves a standardized method to communicate a patient’s condition during handovers and is available at http://www.ihi.org/knowledge/Pages/Tools/ SBARToolkit.aspx.

Team training involves effective communication and team functioning skills, which must be learned in order for the staff to gain competencies. Team training is described as “the application of instructional strategies based on well-tested tools (e.g., simulators, lectures, and videos) to a specific set of competencies” (AHRQ, n.d.-c).

High-Reliability Organizations (HROs)

HROs are organizations with systems in place that are exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors. (AHRQ, 2008)

The industries first to embrace HRO concepts were those in which past failures led to catastrophic consequences: airplane crashes, nuclear reactor meltdowns, and other such disasters.

These industries discovered it was essential to identify weak danger signals and to respond to these signals strongly so that system functioning could be maintained and disasters could be avoided.
Basic characteristics for HROs applied to hospitals include the following basic concepts:

Hypercomplexity—Hospitals are extremely complex systems in which multiple sequential and nonsequential tasks are carried out by multiple staff to produce outcomes. As any health care worker will tell you, “There is no such thing as a simple operation.”

All operations depend on numerous staff to perform their roles perfectly and at the right time to produce effective outcomes. An error by just one team member can easily cascade into disastrous outcomes.

Tight coupling—Interdependent tasks—These are tasks performed rapidly that require perfect coordination to deliver the right care to the right patient at the right time. Operating rooms and critical care areas have tight coupling.

Extreme hierarchical differentiation—During times of crisis, authority is granted to the person with the best skill set to do the job. An example of this would be two staff members, a nurse and a physician, responding to a cardiac arrest; the nurse is ACLS certified and the physician is not: the nurse leads the code.

Multiple decision makers in a complex communication network—Within a hospital setting, many people make decisions regarding the patient’s care. Coordination and effective communication between all decision makers is essential.

High degree of accountability—HROs have a high degree of accountability when errors occur with severe consequences. Hospitals do not routinely deal in mass injuries such as those resulting from a plane crash; however, the medical profession and legal system hold medical professionals to a higher accountability standard when adverse events occur.

Need for immediate and frequent feedback—Continuous feedback is essential because it enables the team to make rapid adjustments when unpredictable events occur. Also, it assists the team to discern what is important to act on versus what is not as important and can be handled later. When staff is afraid to voice their concerns for patient safety, the patient is subjected to serious risk.

The final HRO characteristic relates to compressed time constraints—The patient requires care 24 hours a day/7 days a week. When resources are stretched (such as when there is a shortage of nurses), important tasks may be delegated to ancillary staff during a shift or carried over for the next shift’s nurse to carry out. Accurate communication of the patient’s needs is necessary to prevent adverse events.
Systems Thinking

It takes a community of diverse medical staff, each performing his or her piece of a complex process perfectly, to provide safe patient care. This is not an easy thing to do and requires systems thinking to integrate the pieces of care into a holistic framework in which to target patient-safety efforts.

Hospitals are complex systems. Health care systems are composed of multiple, interrelated activities called processes that result in patient outcomes on a daily basis. When human error occurs, a chain of subsequent events similar to a domino effect can result in patient harm.

An example of a domino effect is when a patient arrives in the emergency room and the physician experiences a delay in obtaining the patient’s prior medical record. The physician then makes an error in prescribing a treatment because he or she did not have the needed information about the patient’s past medical history to make a sound clinical decision.

Another example is when there is a shortage of made-up beds in the intensive care unit because of reduced housekeeping staff. Now, there are delays in admissions to the intensive care unit due to the delays in housekeeping staff cleaning the beds. This shortage of housekeeping staff created a domino effect which has the potential to cause an adverse event.

Simple solutions are not effective for complex problem solving when there are multiple, interrelated activities that result in a range of potential outcomes for patients. Senge (1990) described systems thinking as “a conceptual framework, as a body of knowledge and tools that has been developed over the past fifty years, to make the full patterns clearer and to help us see how to change them effectively.”

Senge identified systems thinking as one of the essentials an organization must have to build a learning organization, along with personal mastery, mental models, building a shared vision, and team learning.

He argued that one of the key problems in management is that simplistic frameworks are applied to complex systems, which results in a focus on only the parts rather than the whole, and produces less than optimal results.

The other difficulty lies in the time line related to cause and effect. In complex systems, many times it takes years for the full effects of multiple, interrelated activities to fully play out.

When a nurse makes a medication error, the easy and simple solution is to counsel the nurse and reinforce the policy of checking two patient identifiers. However, this solution is not effective because
nothing in the system design changed to prevent the occurrence from happening again.

The Institute of Medicine (IOM, 2001) stated that complex adaptive systems have both the freedom and the capacity to respond to stimuli in many different and fundamentally unpredictable ways resulting in either innovation or error. The IOM provides the following six aims for health care systems:

■ Safe: Patients should not be harmed by the care that is intended to help them.
■ Effective: Care should be based on scientific knowledge and offered to all who could benefit and not to those not likely to benefit.
■ Patient centered: Care should be respectful of and responsive to individual patient preferences, needs, and values.
■ Timely: Waits and sometimes harmful delays in care should be reduced both for those who receive care and for those who give care.
■ Efficient: Care should be given without wasting equipment, supplies, ideas, and energy.
■ Equitable: Care should not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Achieving a higher level of quality is essential as a first step in improving the quality of care overall; this requires new designs of systems that prevent error and minimize harm.

Human Factors

The field of human factors is used to analyze the environment and interfaces between the human operator and the system to produce safer systems of care.

Licht, Polzella, and Boff (n.d.) researched the broadening of the term human factor and noted that there appears to be a broadening of the focus with application to many fields. The authors stated that originally the focus of human factors was

On the design of military man-machine systems. It is obvious that this focus has expanded to include private industry and consumer products as well. Thus the field has moved from a discipline born in a postwar militarily orientated engineering environment to a more global manufacturing and consumer oriented environment. (n.d.)
Kohn, Corrigan, and Donaldson (2000) acknowledged that human factors are just beginning to be applied within health care.

Reliability

The IHI (n.d.-c) defines reliability theory as “a scientific method of evaluating, calculating, and improving the overall reliability of a complex system.” These concepts have been embraced by and used effectively in industries such as manufacturing, nuclear power, and aircraft carriers. Using reliability concepts, these industries have improved the rate at which they consistently produce appropriate outcomes and prevent adverse events.

Reliability theory, when applied to health care, has the potential to help reduce defects in care or care processes and increase the consistency with which appropriate care is delivered and thus to improve patient outcomes.

Unfortunately, health care is not reliable yet. Indeed, the health care provided to patients has a long way to go to reach the level of success attained by HROs. Remember: If an audit of care provided shows 90 percent compliance with standards, this means that 1 out of every 10 patients did not receive the optimum care that the system designed. One patient out of 10 may suffer an adverse event because of the low reliability of the process designed by the system.

Evidence-Based Medicine

Sackett and Rosenberg (1995) explained evidence-based medicine (EBM) as the ability to track down, critically appraise and incorporate evidence into clinical practice. They feel that as studies of valid evidence increase, so does the requirement for the medical community to develop the skills necessary to understand, evaluate, and make best use of that evidence for patients.

One of the benefits of EBM is that greater consistency of treatment appropriate to the patient’s symptoms might be achieved. There is wide variation in the treatment provided by physicians to patients (Wennberg & Gittelsohn, 1982), and variation is a source of medical errors that can lead to adverse events. Recently, the AHRQ stated that

Every day, millions of Americans receive high-quality health care that helps to maintain or restore their health and ability to function. However, far too many do not. Quality problems
are reflected in a wide variation in the use of health care services, underuse of some services, overuse of other services, and misuse of services, including an unacceptable level of errors. (n.d.-d)

The goal of patient safety applied to EBM is to deliver the right treatment at the right time, to the right patient, all of the time. If the patient receives the right care only 90 percent of the time, that is simply not enough to be an acceptable standard of care.

**Reporting Systems**

The medical community, mortality and morbidity conferences, grand rounds, and peer review all currently share the same shortcomings: a lack of human factors and thinking about systems. This leads to these review processes having a narrow focus on individual performance to the exclusion of contributory team and larger social issues. This lack of a systems focus also leads to hindsight bias, which is the tendency to search for errors rather than for the numerous causes of error induction (Barach, 2000).

Reporting systems have the potential to provide information that can be used to prevent future adverse events from occurring and also to enhance learning of staff; however, voluntary reporting systems have their own set of problems.

Despite aviation’s success stories, physicians remain reluctant to use reporting systems. The studies have demonstrated that physicians are reluctant to participate in programs to report medical errors and that underreporting of adverse events may be as high as 96 percent (Harper & Helmreich, 2005).

The AHRQ’s findings suggest that the success of a reporting system is determined by the attitudes and perceptions of frontline care providers. Prior to implementing an event-reporting system, there needs to be an assessment of the opinions of care providers to identify critical barriers to reporting. Those issues should be dealt with prior to implementing a reporting system.

**Use of Tools**

Proper tools are a necessity. Abraham Maslow (2009) once said, “If the only tool you have is a hammer, you will see every problem as a nail.”
The world does not operate in a linear fashion. When managers continue to solve complex problems with linear action plans, the results are often not as intended. What is needed is a radically new tool kit.

This new tool kit would contain new skills. The new skills would be congruent with the “new paradigm view” of organizations as unpredictable, interactive, living systems, rather than being viewed as machine-like systems.

There are numerous approaches to using tools for every aspect of patient safety, from the basic tools of how to perform a credible RCA of an adverse event to how to perform a health care failure modes and effects analysis.

Checklists are increasingly being used in health care as one of the tools to help ensure patient safety. An example of this is the central line checklist, a tool whose use has resulted in a dramatic reduction in the prevention of central line infections (Pronovost et al., 2006).

There is also the World Alliance Surgical Safety Checklist (World Alliance for Patient Safety, 2008), which was developed to assist in minimizing the most common and avoidable risks for surgical patients.

In this light, there are free starter kits such as Botwinick, Bisognano, and Haraden’s Leadership Guide to Patient Safety (2006) that the IHI offers online. In fact, there are numerous online resources for tools to use when implementing a patient safety program, such as those listed in Table 1.1.

<table>
<thead>
<tr>
<th>WEBSITE</th>
<th>WHAT’S IN IT</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.ahrq.gov/qual/pips/">www.ahrq.gov/qual/pips/</a></td>
<td>Agency for Healthcare Research and Quality (AHRQ)</td>
</tr>
<tr>
<td><a href="http://www.ahrq.gov/qual/pstools.htm">www.ahrq.gov/qual/pstools.htm</a></td>
<td>Domains for tools; extensive Hotlinks available: setting and user, patient safety issue area/user and patient safety goals. Also contains team training tools and patient safety culture survey information</td>
</tr>
<tr>
<td><a href="http://www.ahrq.gov/qual/errorsix.htm">www.ahrq.gov/qual/errorsix.htm</a></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.ahrq.gov/qual/hospsurvey09/">www.ahrq.gov/qual/hospsurvey09/</a></td>
<td></td>
</tr>
<tr>
<td>teamstepps.ahrq.gov/</td>
<td></td>
</tr>
<tr>
<td>abouttoolsmaterials.htm</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.mgma.com/pppsahome/">www.mgma.com/pppsahome/</a></td>
<td>Medical Group Management Association (MGMA)</td>
</tr>
<tr>
<td><a href="http://www.patientsafety.gov/">www.patientsafety.gov/</a></td>
<td>United States Department of Veterans Affairs</td>
</tr>
<tr>
<td>safetytopics.html</td>
<td>Resources for how to conduct RCA/FMEA and numerous tools to implement programs such as falls prevention, hand hygiene, and so on</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>WHAT'S IN IT</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><a href="http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/">www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/</a></td>
<td>Institute for Health Care Improvement (IHI)</td>
</tr>
<tr>
<td></td>
<td>Leadership tools, communication</td>
</tr>
<tr>
<td></td>
<td>HFMEA, trigger tools, general tools, and so on</td>
</tr>
<tr>
<td><a href="http://www.healthpartners.com/files/34649.pdf">www.healthpartners.com/files/34649.pdf</a></td>
<td>Health Partners: Ambulatory Care</td>
</tr>
<tr>
<td></td>
<td>Ambulatory care tool kit</td>
</tr>
<tr>
<td><a href="http://www.ismp.org/tools/abbreviations/">www.ismp.org/tools/abbreviations/</a></td>
<td>Institute for Safe Medicine Practices (ISMP)</td>
</tr>
<tr>
<td></td>
<td>Medication safety tools: error-prone abbreviation list</td>
</tr>
<tr>
<td><a href="http://www.nursingleadershipcongress.com/ToolKit.asp">www.nursingleadershipcongress.com/ToolKit.asp</a></td>
<td>Nursing Congress</td>
</tr>
<tr>
<td></td>
<td>Leadership tools for implementing patient safety; includes financial</td>
</tr>
<tr>
<td></td>
<td>aspects of patient safety</td>
</tr>
<tr>
<td><a href="http://www.ccforpatientsafety.org/patient-safety-solutions/">www.ccforpatientsafety.org/patient-safety-solutions/</a></td>
<td>Joint Commission in collaboration with WHO</td>
</tr>
<tr>
<td></td>
<td>Nine patient safety solutions</td>
</tr>
<tr>
<td><a href="http://www.psnet.ahrq.gov/browseResourceType.aspx?resourceTypeID=203">www.psnet.ahrq.gov/browseResourceType.aspx?resourceTypeID=203</a></td>
<td>Patient safety network: AHRQ</td>
</tr>
<tr>
<td></td>
<td>134 resources and tools for patient safety</td>
</tr>
<tr>
<td></td>
<td>Team training tools</td>
</tr>
<tr>
<td>teamstepps.ahrq.gov/</td>
<td>AHRQ</td>
</tr>
<tr>
<td></td>
<td>Evidence-based team training tools</td>
</tr>
<tr>
<td></td>
<td>Patient rounding tool kit, patient safety resources</td>
</tr>
<tr>
<td><a href="http://www.npsf.org/pat/pafrrg/">www.npsf.org/pat/pafrrg/</a></td>
<td>National Patient Safety Foundation (NPSF)</td>
</tr>
<tr>
<td></td>
<td>Resources for patient safety</td>
</tr>
<tr>
<td><a href="http://www.who.int/patientsafety/safesurgery/en/">www.who.int/patientsafety/safesurgery/en/</a></td>
<td>Patient safety surgical checklist and other resources</td>
</tr>
<tr>
<td></td>
<td>Curriculum for patient safety for WHO International medical students</td>
</tr>
<tr>
<td><a href="http://www.massmed.org/AM/Template.cfm?Section=Home6&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=3925">www.massmed.org/AM/Template.cfm?Section=Home6&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=3925</a></td>
<td>Massachusetts Medical Society (MassMed)</td>
</tr>
<tr>
<td></td>
<td>Patient safety curriculum</td>
</tr>
</tbody>
</table>
CONCLUSION

Accreditation programs are usually voluntary in nature and involve external peer review. Standards are the foundation for accreditation programs and they evolve over time, becoming increasingly challenging as compliance to the established set of standards is obtained. Standards have the potential to generate optimal performance.

Patient safety concepts involve culture, communication, systems thinking, human factors, reliability, EBM, reporting systems, and the use of tools. Increasingly, patient safety concepts are being included in accreditation standards.

REFERENCES


Maslow, A. (2009, November 11). *If the only tool you have is a hammer, you tend to see every problem as a nail.* Retrieved from http://blog.dreamthisday.com/2009/11/abraham-maslow-if-only-tool-you-have-is.html


