

JAMES PARK, MD, MHA

Addressing AMBULATORY PATIENT SAFETY in Your Practice

Reducing errors in care requires establishing a culture of safety, systematic reporting, consistent follow-up, and sustained commitment.

Do no harm. It is the bedrock principle of medical practice and the first priority for any medical practitioner. However, the Institute of Medicine, in its groundbreaking “To Err Is Human” study, showed that the medical community is not living up to this important principle. The study estimated that up to 98,000 people die annually in United States hospitals because of preventable medical errors.¹

Subsequent studies have increased that estimate, and health care leaders, regulators, and insurers have crusaded for a renewed focus on improving patient safety.² While advances such as electronic prescribing have helped to improve outpatient safety, the majority of effort and research has been dedicated to inpatient safety.³

Errors in the inpatient setting tend to be acutely recognized, but outpatient care is equally hazardous, generating more than half of all paid malpractice claims and two-thirds of claims involving major injury or death, according to one study.⁴

Our University of Washington-affiliated community hospital outside Seattle chose several years ago to focus on patient safety in its outpatient clinic network, which

includes 224 physicians in more than 30 locations. We developed and implemented a program for detecting, identifying, and addressing safety problems in our clinics that could be pursued by practices of all sizes.

Safety and quality are not the same

Patient safety is obviously a key facet of how well you care for the patient. For this reason, many institutions have ambulatory quality committees that also consider safety. However, we have found these committees tend to spend more time on measuring quality than analyzing safety issues. Some institutions have recognized this and formed safety committees, but we find these committees typically combine both inpatient and outpatient safety and, for the reasons described earlier, outpatient safety gets overshadowed.

Ambulatory patient safety should have its own committee and dedicated focus. We began our initiative by creating precisely this type of group.

Every person working in the clinic has a role in patient safety, so the ideal committee should have representatives of every job role, including a front-desk worker, medical

About the Author

Dr. Park is associate medical director for the clinical network of Valley Medical Center in Renton, Wash., and is a practicing family physician. Author disclosure: no relevant financial affiliations disclosed.

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assistant, registered nurse, physician, pharmacist (if you have one in-house), laboratory technician, etc. If you have more than one clinic, make sure to have representatives from each on the committee. Practical concerns may limit the size of your committee, but it is important to aim for broad representation.

Building a culture of safety

Our committee's first task was discerning what kind of safety culture we already had in our network. We sent everyone in our clinic network a survey (<http://1.usa.gov/1TW3vG6>) developed by the Agency for Healthcare Research and Quality (AHRQ) that asks employees for their opinions about patient safety, medical errors, and how errors are reported in their facility. Although it is labeled a "hospital survey," the questions would apply to any size practice.

We were pleasantly surprised to find that the results of the survey showed we were close to meeting or even exceeding several national benchmarks. For example, 64 percent of survey respondents said they believed our system and clinical processes were able to prevent, identify, and correct problems that could potentially harm patients, compared with the national benchmark of 65 percent. Also, 57 percent agreed that providers and staff talked openly about office problems (58 percent nationally), 87 percent said we discuss ways to prevent errors from happening again (79 percent nationally), and 78 percent reported that staff were willing to report mistakes they observe in the office (73 percent nationally).

Although the survey results were largely positive, they only measured the staff's impression of our safety culture – not whether our processes were truly safe. For example, even though the survey asked people if they were comfortable reporting errors, it didn't ask if they had ever actually reported an error – and, it turned out, many never had.

Create a reporting system

We recognized that error reporting was virtually nonexistent, as it likely is in many organizations. Employees were not aware that they needed to report errors, nor did they know what constituted an error, how to report an error, or what the ramifications would be both for the person who erred and for the person who reported the error. The improvement maxim goes, "You can't improve it if you can't measure it," so we set out to teach our staff members about reporting and create a culture in which they felt comfortable reporting.

The mechanics of the reports were straightforward. We set up an electronic application on the clinic online dashboard that any employee could access and use to enter information about an error, including when it occurred, who was involved, the type of error, and how it affected or potentially could have affected a patient. We use a program made by Quantros, but there are several commercially available systems. Small practices don't necessarily need special software for this purpose and could use an Excel spreadsheet instead. Staff could enter the information in the spreadsheet or send a message describing the error to a designated safety manager, who would maintain the spreadsheet.

In our organization, the error report initially goes to our patient safety officer, who then forwards it to that clinic's manager for investigation or, in the case of major errors, discusses it with the organization's managers.

Obviously, the idea of tracking and discussing a practice's errors will give some physicians and clinic managers pause, fearing the potential liability of such information being accessed by plaintiff attorneys. Before instituting a safety program, it is important to obtain legal advice to ensure that both the information contained in error reports and the discussions within a safety committee are protected from disclosure. In our case, Washington state law allows health care entities to establish

■ Outpatient safety is often overshadowed by efforts to improve safety and quality in the inpatient experience.

■ The safety committee should represent every job that touches patient care in the clinic.

■ A staff survey can show if your practice already has a culture of safety.

Coordinated Quality Improvement Programs that have discovery limitations and are protected from subpoenas. Other states may have similar laws to encourage health care quality improvement.

Any reporting system needs established standards to ensure errors are reported and addressed quickly, which also builds accountability. We tell staff members to report an error within two days of the event. Clinic managers who receive reports forwarded by our patient safety officer must review them within two days and complete their investigation within 14 days. We developed a monthly report that shows which events have been reviewed, investigated, and closed.

Training needs depend on the complexity of the reporting system. But impressing on staff the importance of using the error reporting system is a never-ending commitment that requires the attention of clinic leaders. In our case, each representative on the committee was charged with going back to his or her clinic and reminding staff of the importance of error reporting. In addition, as I visit each clinic as part of leadership rounding and hear about errors or receive emails about errors, I always ask if the error has been reported in the system.

For added accountability, the monthly report lists the errors by clinic, which we can use to see which clinics are not reporting many errors. We can then ask about their reporting and, if necessary, provide more training at those locations.

Finally, with regard to error reporting, it is vital that physician leaders take a lead in discussing errors. Physicians who are open and honest about mistakes and willing to discuss improvements they would like to make have an immensely powerful effect on building a culture of safety. Conversely, physicians who deny culpability, blame others for their mistakes, and refuse to discuss errors destroy a practice's ability to improve safety.

Dealing with errors fairly

As important as creating a system for reporting errors is developing a system for addressing those errors and determining the correct reaction. We implemented a system sometimes called "Just Culture," which allows an organization not only to hold people accountable for their actions but also to provide a supportive environment with the knowledge that mistakes are going to be made.⁵

Many errors happen not because of

■ Your internal system for reporting and reviewing errors must be protected from legal disclosure.

■ Errors should be reported quickly – and dealt with quickly.

■ "Just Culture" holds employees accountable for errors and supports them once the error is made.

"JUST CULTURE" CATEGORIES

Error type	Example	Response	Example
Human error	"I gave the wrong vaccine because I misread a label."	Console employee and correct source of error.	"Goodness, you made a mistake. How are you feeling? How can this process be improved?"
Negligent behavior	"I gave the wrong vaccine because I forgot to read a label."	Counseling/training	"To keep our patients safe, it is important to learn and follow the processes that we have put into place. Please let me know if you have any difficulty with maintaining these processes. How can this process be improved?"
Reckless behavior	"I gave the wrong vaccine because I didn't bother to look at the orders."	Punishment	"This is a written warning."
Knowing violation	"I gave the wrong vaccine because I chose to ignore the vaccination process."	Punishment	Depends on severity of behavior.

Adapted from Marx D. Patient Safety and the "Just Culture": A Primer for Health Care Executives. New York, NY: Columbia University; 2001.

incompetent or uncaring people but because processes are flawed and lead people to make mistakes. In these cases, the manager's job is to console the employee while also making efforts to improve the process so as to prevent future errors or prevent errors from resulting in patient harm.

In cases where error has occurred because employees did not follow well-established processes, additional coaching or training reinforcing those processes may be necessary. Only reckless or intentional errors, which thankfully are rare, require discipline. (See "Just Culture" categories" page 25.)

In its best form, a Just Culture will result in managers dealing with errors in a consistent manner across the organization and employees feeling safe that they won't be unfairly penalized for making mistakes. Remember, if the process is not clear or the reactions are considered arbitrary, employees are much less likely to report errors.

A group interested in implementing a Just Culture could follow these steps:

- Educate clinic leaders on Just Culture.

There is information available online, such as these resources from AHRQ: <http://1.usa.gov/1CZAEJ9>.

- Train management on Just Culture with an emphasis on categorizing errors and basing responses on these categories. If your organization has a human resources department, it must be involved and engaged in this training.

- Present and explain Just Culture to staff and physicians. Once again, making sure the categories and ramifications are clear will go a long way toward getting employees to embrace the error reporting system as a whole.

- Choose a Just Culture "champion," such as a physician leader or practice administrator, to work with managers on an ongoing basis and make sure the system's concepts are being consistently applied across the organization.

Evaluate trends and be proactive

Implementing an error reporting system and the Just Culture philosophy has resulted in a large increase in the number of errors reported in our organization (see "Error reporting"). The year before we began teaching staff about reporting, we received only 26 reports. We began focusing on error reporting in mid-2011 and received more than five times as

many that year. By last year, the number had grown to 556.

We benefitted quickly from these error reports as we were able to identify certain areas that generated the most problems. For instance, test specimen labeling was a major source of errors, with specimens sometimes never being labeled, being labeled as belonging to the wrong patient, or missing labels that had fallen off and gotten lost. To address proper labeling, we developed a humorous video, which we show to all new employees during orientation (<https://www.youtube.com/watch?v=CG5IMhH-TYk>), and we have seen far fewer labeling problems.

We also noted numerous vaccination errors, such as patients receiving the wrong vaccine or receiving it too early or too late in the vaccination schedule. We discovered that staff across the organization used a wide variety of methods to administer and track vaccines and vaccinations. We created a vaccine error reduction program that standardized the process, which has led to a reduction in vaccine errors from 40 in December 2012 to only 10 in the last quarter of 2014.

The reports also pointed to problems with medication safety. In the ambulatory setting, we need to worry about not only the medications we administer on-site but also those prescribed to our patients. Even a small office deals with hundreds of prescriptions a day, and the potential for error is vast. Our organization's medication safety officer reports to the safety committee on medication errors every other month and has helped us develop ways to better label medication and keep "sound alike-look alike drugs" stored far enough apart to prevent mix-ups. We have also placed more indication warnings on prescriptions and improved the medication administration process.

ERROR REPORTING

YEAR	NUMBER OF SAFETY ERROR REPORTS
2010	26
2011	147
2012	442
2013	474
2014	556

■ Dealing with errors in a consistent and predictable manner will increase the likelihood that staff report them.

■ A "Just Culture" champion can make sure the system is being managed correctly.

■ Use error reports to find and fix flawed processes, not just punish employees.

Any reporting system needs established standards to ensure errors are reported and addressed quickly, which also builds accountability.

As a result of our increased focus on safety, we are able to quickly identify and fix problems before they become trends. For example, if a provider orders a Pap smear and doesn't get the results back quickly, he or she might track it down themselves. They then report the error in the system, and we can discover the source of the delay and prevent it from happening in the future. Four years ago, with physicians working in a safety vacuum, the problem may have gone unnoticed for weeks and become widespread, hampering patient diagnoses.

Who is responsible and how do you pay for this?

Early in the process of setting up a safety program, your practice must determine who on your staff will operate it and oversee it. Responsibilities include setting up the reporting system, training staff, reviewing generated reports, and responding to the problems identified. Many times, this can mean finding someone passionate about safety to take up the job. Unfortunately, the norm is that this someone performs this work "in addition to" current duties. In our case, we spent several years trying to handle this work with existing staff but have since added a part-time employee (0.5 full-time equivalent) to administer the program. Dedicating staff for this work is likely more of a need for larger organizations. A four-physician practice can likely discuss events in a weekly meeting and design and implement new processes fairly easily. In a 200-plus provider group, however, implementation is a large task, and it is necessary to fund the employment of dedicated staff for this work.

Besides staffing costs, there are expenses associated with your reporting system, although as described earlier, a simple Excel spreadsheet might suffice for many smaller practices.

Unfortunately, the costs of instituting a safety program are generally not supported by direct payment. Everyone talks about the importance of safety, but it's a different mat-

ter when it comes to paying for it. That may change as we move toward more value-based reimbursement. In the meantime, however, the reality is that a patient safety program ultimately will be an additional expense for your practice.

Of course a safety program accrues financial benefits as well – they just may be difficult to measure. For example, discovering and fixing inefficient and error-prone processes can improve your practice's throughput and output, which can also reduce your overhead. Operating a practice more safely could potentially avoid malpractice claims as well. As a practice starts tracking errors, there are a lot of "holy cow" moments – errors that seemingly defy logic and are so clearly potentially harmful to patients and the practice that the benefits of finding them and avoiding them will be obvious.

Keep measuring and improving – the work is never done

In any quality improvement initiative, regular reassessment of progress is essential. Initial gains will eventually plateau or may even begin to regress. About two years after starting the safety initiative, we checked our progress. We discovered that engagement was not as robust as we had hoped across all our clinics, there was confusion over how quickly errors should be investigated, and employees still were unsure of the Just Culture process. This led us to make a number of changes, including ensuring that the safety committee represented more disciplines and locations, tweaking error reporting standards, and beefing up education for the staff.

Admittedly, progress is slow. We are four years into this effort, and sometimes we think we've gotten a lot accomplished. Other times, however, we feel that we've only begun to address the problem.

Lessons learned

Ambulatory patient safety needs its own "space" so it gets the attention it deserves,

■ Error reports can identify problem areas much faster, preventing them from becoming trends.

■ Your practice may need dedicated staff to deal with error reports.

■ You are likely not going to be directly reimbursed for a safety program, but you may benefit from fewer legal claims and greater efficiency.

Many errors happen not because of incompetent or uncaring people but because processes are flawed and lead people to make mistakes.

■ Practices need to continuously monitor their safety programs and look for improvements.

■ Patience may be necessary as progress to improve safety can be slow.

while still coordinating with quality and safety work going on in other areas of the organization. A committee or other oversight group should be multidisciplinary to illuminate all sides of issues. Reporting is the first step since we can't fix what we don't know about. A reporting system is necessary, and staff need to know what, when, and how to report. People need to feel comfortable reporting errors, which means managers need to be very clear and consistent in describing how they deal with each kind of error. Finally, the work of creating a patient safety program never ends,

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and practices should periodically check in to gauge their progress and make improvements as necessary. **FPM**

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