

What's the Patient Safety Improvement Corps (and what's in it for me)?

By Tina Nudell, MS, education specialist, Martha Morgan, education technician, and Caryl Lee, RN, MSN, program manager

What's the PSIC?

SINCE 2003, the VA National Center for Patient Safety (NCPS) and the Agency for Healthcare Research and Quality (AHRQ) have been partners in the creation and implementation of the Patient Safety Improvement Corps (PSIC).

Dr. John Eisenberg, Marge Keyes and others at AHRQ developed the idea for the PSIC several years ago. Their primary goal was to reduce adverse events and patient injury nationally by providing robust, functional patient safety knowledge and analytical skills to small teams from all 50 states and the District of Columbia (DC).

Beyond this primary goal, AHRQ hoped each team would be motivated to share patient safety information and approaches within their own state; that positive effects of the PSIC would be sustained over time.

What did VA do?

An AHRQ advisory group selected VA to develop and conduct a comprehensive training program for state health officials and their selected partners, based on the inclusive training program we offer VA professionals. PSIC provided NCPS an opportunity to work with state-level experts, share VA's patient safety approaches and tools, and see if these same approaches and tools could be successfully used in non-VA settings.

NCPS eagerly joined in with AHRQ to:

- Design and roll-out the PSIC curriculum (three four-day, face-to-face sessions held in September-January-May of 2003-04, 2004-05, and 2005-06).
- Recruit state teams.
- Manage day-to-day program operations.
- Consult with each team on their state-level project.
- Create a computer-based training (CBT) package.

All 50 states and D.C. were invited to participate during the course of the three-year project, as illustrated on the map on the back page of this issue of TIPS.

While most of the PSIC content was based on VA patient safety training and tools, several outside experts presented additional topics during the sessions. State teams also reported on their projects during the final week of training.

Here is a listing of the major content areas we covered:

- Patient Safety: Taking the Systems Approach
- Human Factors Engineering
- Root Cause Analysis
- Healthcare Failure Mode and Effect Analysis
- Business Case for Patient Safety
- Confidentiality Issues
- Measurement and Evaluation Culture
- Leadership
- AHRQ Patient Safety Indicators
- Mistake Proofing
- "Just Culture"
- Probabilistic Risk Assessment

State Projects

These projects reflected team priorities and ranged from state-wide training and consciousness-raising, to development or implementation of adverse event reporting legislation, to RCAs and HFMEAs, to meeting JCAHO goals.

So, what's in it for me?

A customized version of the CBT package that was built around PSIC content will be distributed to Network Patient Safety Officers and Facility Patient Safety Managers this fall. We anticipate that the various modules included in the CBT package will be helpful to you in delivering "just-in-time," refresher, and, perhaps, some advanced patient safety training. Review the web links provided on the back page of this TIPS issue, too. We think you can learn a lot from the information in them!

Conclusion

As noted earlier, NCPS was eager to join with AHRQ on this project. Many of the approaches and tools VA developed have been applied successfully at the state level, based on many successful projects designed and completed by the state teams.

In addition, AHRQ contracted with the RAND Corporation to conduct both short- and long-term evaluations of the effects and sustainability of the PSIC. We look forward to learning from those evaluations, too.

If you have any questions about the PSIC, or you would like to be introduced to your state-level colleagues to exchange ideas, please contact us via VA Outlook or through our NCPS public email: NCPS@va.gov.

“And the ‘EYES’ Have It”: Ear Drops, That is...

By Carol Samples, program analyst, NCPS, and Mary Burkhardt, RPh., M.S., FASHP, Medco

WHEN EAR DROPS are instilled in a patient’s eyes, it is usually immediately obvious: patients quickly let us know that something is very wrong.

They complain of burning and stinging; later they may notice redness, swelling, or blurred vision. They have their eyes flushed with copious amounts of water or saline, sometimes having warm or cold compresses applied. Some patients may require immediate first aid in the ER or ophthalmology clinic.

In a search of our Patient Information System database (nick-named SPOT), we found that one-third of VA facilities have reported ear drops placed in a patients’ eyes.

The most common medications instilled in patients’ eyes are those used to clear the accumulation of ear wax (ceruminolytics), such as carbamide peroxide. Other ear medications, however, have also been instilled in patients’ eyes.

Sound-alike/look-alike medications are a great source of adverse drug events. Eye drops and ear drops meet both criteria with ease. “Optic” and “otic” sound alike and look alike and the vials from which drops are dispensed generally look alike, too. The fact that ears and eyes are so close together also adds a “human anatomy factor” to the equation.

Further complicating may be the misuse of the term “eye-dropper” to administer both types of medications.

BCMA can prevent administration to the wrong patient or confirm whether ear or eye drops are required, but it cannot absolutely prevent ear drops from being instilled in the eyes.

A snapshot of the problem

Seventy-nine percent of the reports in SPOT were actual events and 21 percent were close calls:

- 68% occurred when staff administered medications.
- 11% took place when patients administered their own medications.
- 19% involved dispensing or instructions in the pharmacy.
- 2% occurred during prescribing.

Circumstances included:

- Ear and eye drops were side-by-side in the pharmacy; wrong vial selected.
- Instructions were read as “1 drop optic” rather than “otic.”
- A patient took ear drops from the top of a med cart while a nurse was checking BCMA.
- Ear drops were dispensed as eye drops following cataract surgery. The patient notified staff of the mix-up.
- Instructions indicated using drops to treat an affected eye, conflicting with verbal instructions to use the drops in the ear. The patient used them in his eyes — but called to complain of an ear ache!

Interestingly, one facility assessed the level of events in a unit devoted to blind patients. The unit reported an extremely low incidence of eye medication events. Because it was a primary treatment unit, staff surmised that the low incidence was driven by the nature of the unit’s mission. This included staff carefully reviewing labels on a routine basis because patients were often on multiple medications for each eye.

Some recommendations from NCPS

- At a minimum, the patient label should be on the actual container; further, it is recommended to also use a patient label on the carton.
- Keep meds in original box if the box has a picture of an ear or eye. Pictures are often on boxes, not on vials.
- Consider providing ear drops in snap-top pharmaceutical boxes or in a distinctive vial with ear symbols or pictograms. This will keep ear drop containers physically distinct from eye drops.
- Separate ear and eye drop vials on pharmacy shelves and med carts.
- Remove discontinued medications from med carts when therapy is complete to prevent a future mix-up with another patient’s medications — or a future prescription for the same patient.

- Confirm medication with patients before administering ear drops.

Looking toward the future: Reducing the risk of injury

- Test the use of other less caustic substances for removal of ear wax. For instance, a review of research by Cochrane¹ indicates that there may be no difference in the use of normal saline as compared to other ceruminolytics.
- Administer eye and ear drops on different schedules to reduce the possibility of a mix-up.
- Develop ear care protocols designating specific staff responsibilities, such as a request for the patient to turn his/her head to the side.
- Work with manufacturers to design distinctive packaging and vials for eye and ear drops so they are very different.

Additional issues

Since there are so few otic medications, sometimes eye drops are used for the ear — but ear drops were never intended for use in the eye. Eye tissue is much more sensitive than ear tissue. Eye medications are specially buffered and formulated for ophthalmic use.

Sometimes the same “topical” drug is formulated in both eye and ear preparations. Even though these drugs can have different brand names, storing them together in the same place increases the likelihood of a mix-up in pharmacy. Separate sections for otic and ophthalmic drugs is preferred.

Mix-ups when dispensing or administering ear and eye drops are not uncommon, considering the number of reports from individual facilities and the number of facilities reporting. From an environmental and human factors perspective, we must do more to create barriers to prevent this type of adverse drug event.

Reference

1. “Ear drops for the removal of ear wax,” The Cochrane Database of Systematic Reviews 2006, Issue 2, www.cochrane.org/reviews/en/ab004326.html.

Communication Matters – Part II: Provider-to-Provider Communication

By Amy Carmack, MA, education technician

EFFECTIVE COMMUNICATION between healthcare professionals is critical for good patient care. Like oil in a machine, communication fosters fluid workplace roles and responsibilities; without it, parts in the machine do not work as effectively or efficiently as the should.

In this second article in our series on communication in the healthcare workplace, we will explore the complex and ever-evolving role of communication between healthcare providers.

Poor communication *always* affects staff satisfaction and influences patient outcomes.¹ It often fosters an unhealthy work environment for staff and patients. One's role in the healthcare organization does not matter – one must communicate effectively with others!

This article will address the two most important components of communication in the healthcare environment, relationship building and information dissemination, as well as discuss communication strategies for improving these traits.

Relationship building for better communication

Researchers have identified inter-professional relationship building to be a crucial issue when delivering and interpreting information. Relationship building can be assisted, or hindered, by the communicator styles utilized by communicators. Pioneer communication scholar Robert Norton identified nine communication styles that people use when communicating.² For our purpose, four of those styles warrant examination for use in healthcare.

- Dramatic — stories and narratives used to highlight or state content.
- Animated — physical or nonverbal cues used, such as facial expressions, eye contact, and gestures, to communicate the message.
- Attentive — an active communication style in which the communicator plays dual roles as speaker and listener, emphasizing the use of empathy and listening.
- Open and Friendly — a non-hostile and conversational communication style that helps to develop trust in group dynamics.

The researcher maintains that communicator style is contingent upon con-

text, situation, and time,² which means that communicators can invoke several of these styles concurrently.

Good communication skills can enhance working relationships between providers and patients, and can prevent workplace misunderstandings.³ The proper use of communicator styles can boost these healthcare incentives.

A good communicator should not be deterred by the use of one style for every situation; he or she will use whatever skills are required to get the message across, even if that means mixing and matching styles.

Information dissemination for care

Information sharing is an everyday occurrence for healthcare professionals.⁴ Since multiple healthcare providers can treat a single patient, either from a teamwork approach or multiple hand offs during the patient's stay, information that is transferred has a higher probability of becoming corrupted.⁵

Information can be altered, distorted, or inadvertently created that differs significantly from the original message and its intent. Frustration from message alteration and distrust of the professional abilities of an individual caregiver can lead to "inferior care."⁴

Within the VA health system, several tools exist to aid in the effective dissemination of patient information for care plans. Set as a JCAHO Patient Safety Goal for 2006, hand offs between providers can efficiently transfer patient information.

A marriage between hand offs and SBAR, a tool for sharing pertinent patient information in an abbreviated timeframe, is an opportunity to gather and distribute information. SBAR — which stands for Situation, Background, Assessment and Recommendation — allows for a full dialogue between providers.

The VA also supports and encourages the use of read-back and repeat-back tools. Extremely simple tools to use, read-back and repeat-back require providers repeat information back to each other, either in written or oral form, to clarify the accuracy of the information. Researchers have argued that standardization of "information transfer" can help reduce or eliminate information deconstruction.

Communication strategies for provider communication

As a provider, there are several key points to remember when communicating. Even though we are advocating for constant communication for improved patient care, patient privacy laws and HIPPA regulations should always be upheld. When meeting in a physical location, try to select quiet locations that other professionals and patients do not frequent.

If possible, always perform face-to-face communication. It can reduce the risk of information corruption and it can foster the opportunity for collaborative patient care. If you must engage in written, electronic (e-mail), or telephone communication, *always* employ the use of read-back or repeat-back.

One should utilize a medium of communication that is comfortable and convenient since healthcare is a dynamic and changing environment. Therefore, consider using mediums that will produce the greatest forum for information dissemination and diagnosis and treatment options.

The focus of communication between providers should be the formation of proper and effective care for the patient. Get rid of personal agendas, speak up or be more assertive, and constantly question how you can improve your communication as a provider.

As a healthcare professional, one has a responsibility to the patient and should take all the necessary steps to fulfill that duty — and good communication is a large part of the effort!

References

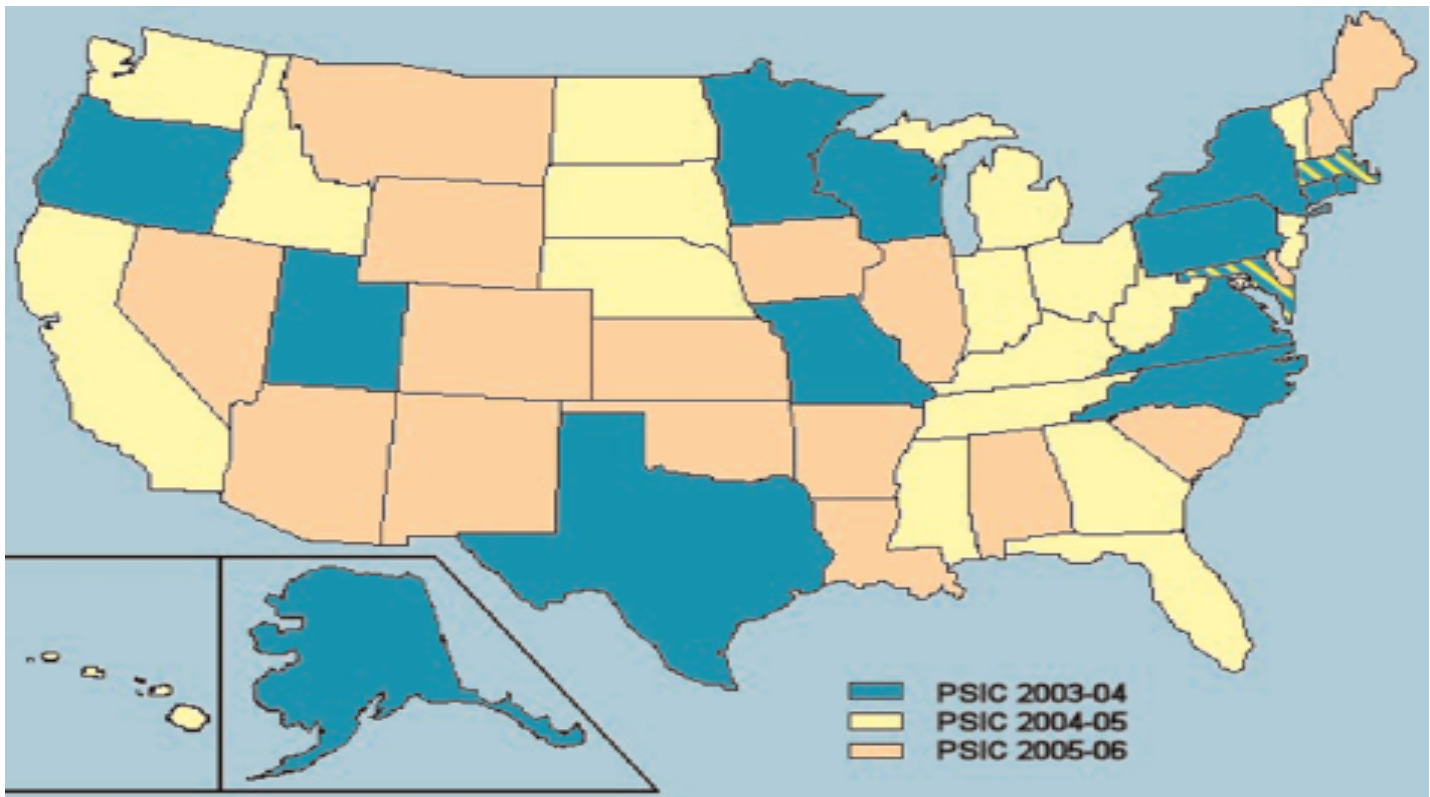
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So, what's in it for me? (Continued)

Listed below are a few guest speaker links and a sampling of state links we've become familiar with that may be of interest. It might be interesting to check out your own state's department of health and hospital association web sites.

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| Mistake Proofing (John Grout) | www.mistakeproofing.com/ |
| Just Culture (David Marx) | www.mers-tm.net |
| Designing Safe Hospitals (John Reiling) | www.hsr.umn.edu/mha/center/4220.pdf |
| California Department of Health Patient Safety Program Manual | www.dhs.ca.gov/lnc/download/PSPM/PatientSafetyProgramManual12-12-2005.pdf |
| New Jersey Department of Health and Senior Services Patient Safety Initiative | www.nj.gov/health/hcqo/ps/ |
| South Carolina Medication Safety Toolkit | www.scha.org/document.asp?document_id=2,3,36,3491 |

The map below shows participation in PSIC by state and year



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