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Broad Trends Identified by the 2005 Patient Safety Survey

By Amelia Landesman, BA, NCPS statistical assistant, and Scott McKnight, PhD, NCPS biostatistician

ONE OF NCPS' PRIMARY GOALS is to improve the culture of patient safety at VA hospitals. We have conducted two surveys to try and gauge the development of this culture.

The importance of both surveys to VA's patient safety program is that NCPS has provided facilities data which allows them to drill down into the various occupation groups listed in Table 1. Facility results for each occupation group can be compared to the network and national results for that group.

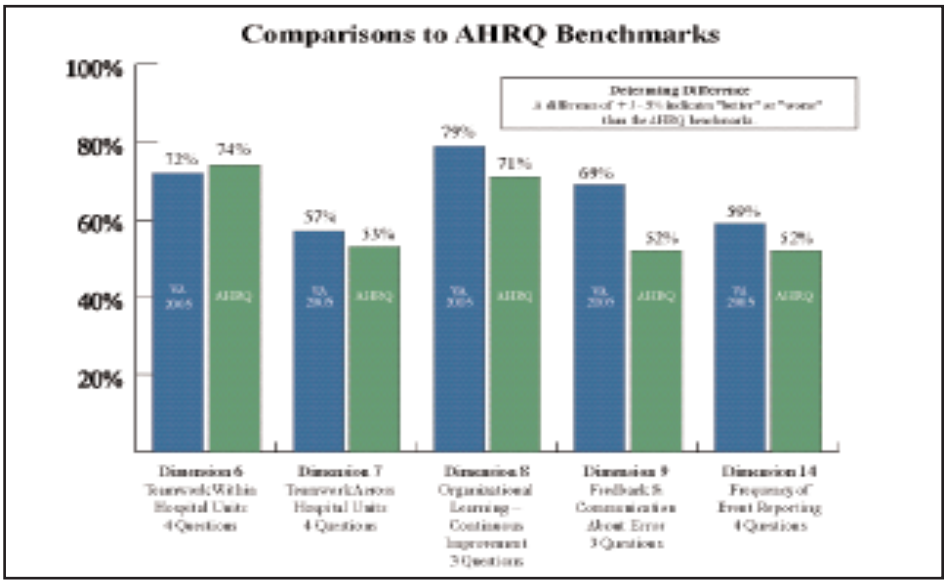
In the 2000 survey, 6,161 VHA employees responded; 45,250 VHA employees responded during the second, held last year (see Table 1). The difference in response counts between the two surveys was primarily due to better methods used to distribute and collect the survey. The wider distribution and sampling in the 2005 survey allows facilities to drill even deeper than occupation groups. They can also drill down to facility's organization units with 10 or more employees.

Patient safety managers and officers can contact Scott McKnight via email (Scott.McKnight@va.gov) to obtain a new data CD that will allow them to drill down by organizational units at their locations.

Culture change can be recognized when staff members understand and perform what is required to create a safe patient experience at the hospital. This can be seen in larger part when:

- Staff are willing to report, discuss, and learn from close calls and adverse events without fear of being punished
- Close calls and adverse events are reported and thoroughly analyzed
- Actions developed to mitigate future events are tested, using quantifiable outcome measures,
- and the level of their effectiveness is reported
- Communication is respectful, efficient, and effective

To measure patient safety culture and its change over time, the new



Our second study was designed with five composite measures in common with an Agency for Healthcare Research and Quality (AHRQ) survey, so comparisons could be made between VA and private sector hospitals. In three measures, VA scored "better" than the AHRQ benchmarks; in the other two, no significant difference was found. VA facilities are studying ways to improve in these areas: Teamwork within Hospital Units and Teamwork across Hospital Units.

Table 1: Response Counts by Occupation (2000 vs 2005)

Occupation	Number of Respondents	
	2000	2005
All Staff	6,161	45,250
Diagnostic	546	3,965
Dietary/Food Svcs	184	1,777
Facilities Mgmt	440	3,212
Admin Svcs	1,133	9,647
Medical Staff	240	2,242
Res.Physician	33	64
Nursing	1,455	10,967
Pharmacy	179	1,884
Social Work	256	1,668
Other	1,023	6,881
Unknown	672	2,943

Sidebar 1: 14 Dimensions of Patient Safety Culture

Measured 2000 and 2005 surveys:

- Overall Perceptions of Patient Safety
- Non-Punitive Response to Error
- Education/Training/Resources
- Shame
- Communication, Openness
- Job Satisfaction
- Patient Safety in Comparison to Other Hospitals
- Perceptions of Patient Safety at Your Facility
- Senior Management Awareness/ Actions in Promoting Patient Safety

Measured only in 2005 survey (from AHRQ survey):

- Teamwork Within Hospital Units
- Teamwork Across Hospital Units
- Organizational Learning/ Continuous Improvement
- Feedback and Communication about Error
- Frequency of Event Reporting

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Patient Harm from Anatomic Surgical Specimen Management in the OR

By Carol Samples, BGS, NCPS program analyst, and Ed Dunn, MD, NCPS director of policy and clinical affairs

SURGICAL PATIENTS can suffer the consequences when anatomic specimens produced from surgical procedures are lost, mislabeled, or processed incorrectly. Because of this, patients can be subjected to unnecessary surgical procedures and medications or experience critical delays in treatment.

We searched our database for adverse events related to management, handling, labeling and transport of surgical specimens.

What happened?

After reviewing more than 40 related adverse events, we organized them into three categories:

1. Specimens were lost:

- Specimens left in operative field.
- Specimens lost in surgical drapes.
- Specimens disposed of as biohazard waste.
- Specimens lost or delayed in transport from the OR suite to the lab.

2. Specimens were mislabeled:

- Unused labels printed for a patient left in OR suite; used for next patient.
- Specimens from multiple patients commingled in same container.
- Specimens from different anatomic locations of a patient commingled in same container.
- Empty specimen containers with patient labels received by the lab.

3. Specimens were placed in the wrong container/medium:

- Specimens not placed in appropriate standard mediums — e.g., tissue sent for anatomic pathology not in formalin (often in saline or no fluid medium); tissue for culture and sensitivity wrongly sent in formalin.

Lost or mislabeled specimens often required that patients submit to a second biopsy procedure for them to receive appropriate care.

Consider the frustration a patient might experience if a prostate biopsy specimen were stored in the same container with those of another patient, thus requiring repeat biopsy procedures.

As another example, consider the anxiety a patient might experience if a breast biopsy specimen were lost, prolonging the uncertainty about medical status and appropriate follow-up care.

Why did these events occur?

RCA teams discovered inconsistencies in handling, communication, and documentation when surgical specimens were processed in the OR suite or were in transit from OR suite to lab.

- Documentation in the OR suite on SK-515 (Tissue Examination Request), accompanying the specimen, was unclear concerning patient identification, type and number of specimens, and lab tests requested.
- Specimens were left on the surgical field or placed inconsistently in the OR suite, such as on a window ledge or on top of a computer.
- Specimen "hand-offs" from OR suite to lab were inconsistent regarding the “chain-of-custody” of personnel involved.

What can be done to prevent these events?

Interventions should focus on processes and communication in the OR suite, as well as communication between the OR suite and lab.

The following recommendations are drawn from the authors, RCA teams, the Pennsylvania Safety Reporting System,[1] and the Association for periOperative Registered Nurses (AORN).[2]

Improve OR processes, communication

- Conduct a pre-op briefing by the surgical team, to include details of anticipated surgical specimens. For instance, discuss: What type? What container or medium should be used? The information can be confirmed by the surgical team to guide the circulating nurse when preparing the correct containers/medium and accurate documentation for the lab. Questions should be discussed with the lab *before* the procedure, not during it.
- Hand off specimens from the surgical field to the circulating RN as soon as they become available.
- Circulator should read back specimen identity and disposition for each specimen hand-off, followed by confirmation from the surgeon, to include clinical information.
- AORN recommends clearly labeling all specimen containers with specimen identity, patient name, Social Security number, and birth date.
- Do not abbreviate on label specimen containers.
- Standardize specimen containers, preferably with translucent lids or bags that allow for sighting the specimen.
- Designate a standardized location in each OR suite for placement of surgical specimens as soon as they are labeled.
- Discard all patient labels from the OR suite at the end of each procedure.
- When available, employ point-of-care bar code labeling and requisitioning for lab specimens in the OR suite.
- Modify the nursing operative report in the surgical package to verify surgical specimen identity, transport, and receipt by the lab.

Improve OR suite and lab hand-off processes, communication

- OR suite and lab must coordinate specimen hand-off in a standardized manner; include documentation of chain-of-custody in this process.
- Do not commingle specimens from the same patient in one container. Place specimens from different anatomical areas of the same patient in separate containers, labeling each individually, then package them together for transport.
- Standardize how OR suite personnel notify appropriate lab personnel regarding specimen delivery.
- Standardize location in the OR suite for storage and pick-up of surgical specimens in preparation for transport.
- Lab management should review the daily OR suite schedule, comparing specimens expected to specimens received.
- Lab should coordinate with OR suite to standardize specimen containers, establishing common expectations for specific specimens in the OR suite and lab.

Bar Code Expansion Project

The bar code Expansion (BE) Project is a new endeavor for VA that is being designed to improve patient safety through the use of wireless technology for specimen collection and identification.

Specimen requisitioning in the OR suite will be achieved using BE technology to print accurate labels for each specimen. Pilot testing will begin in fall 2006, and full implementation across the VHA is expected in approximately two years.

References

1. Penn. Safety Reporting System: Lost Surgical Specimens, Lost Opportunities, Patient Safety Advisory, PA-PSRS, Vol. 3, No. 3; Sept. 2005; *http://www.psa.state.pa.us/psa/lib/advisories/sept_2005_advisory_v2n3.pdf*

2. AORN Guidance Statement: *www.aorn.orgy/about/positions/pdf/SECTS-2e-spechandling.pdf*

Communication Matters: Part 1 — Talking with People

By Amy Carmack, MA, NCPS education technician, and Caryl Lee, RN, MSN, NCPS program manager

BEING A GOOD COMMUNICATOR with patients and colleagues should be at the top of every healthcare professional's list. To effectively persuade others, and to implement and influence change, it's important to learn and use communication fundamentals, whether it be in one-on-one, small, or large group situations.

If you are the speaker…Speak out!

The Advanced Public Speaking Institute reports that public speaking is listed as America's number one feared pursuit — even above death.[1] Experiencing dry mouth, increased heart rate, or nausea before giving a presentation is normal. Don't worry — public speaking is a skill that is honed and practiced over the course of many years.

Be clear and concise

- Do the necessary research. If you want your position considered as valid and legitimate, you must do an extensive background search. You should know your audience and speak directly to their needs.
- Present all relevant information logically. Include information that bolsters your position, such as statistics, testimonials, visual aids (slide presentations, graphics, etc.), and performance records. Provide examples of your main points throughout your presentation, using familiar words to create clear pictures.
- Be brief! Presidential speechwriter Ted Sorensen believed that "brevity is key" when speaking.[2] Get to the point quickly, but plan accordingly — nothing is more embarrassing than people leaving during a presentation.

Provide the audience realistic solutions

- Don't come empty handed! No one likes to be informed of a problem without possible solutions being provided. Use the opportunity to show that you have carefully considered long-term aspects of your position.
- Be prepared for questions. Brainstorm questions you might ask if you were being presented with this position. What kind of answers would you want to hear? Be truthful: don't make up answers just to sound good; be ready to say, "I don't know, but I will be glad to get the information for you." If speaking to a large audience, make sure everyone can hear the questions (or repeat the questions yourself). Use a microphone if one is available.

Be passionate, but compassionate

- Control your emotions, but show your passion verbally. Use different tonal arrangements, vocal variety, inflection, and varying rates of speed to control the mood of the room.
- Choose your words carefully. Use words that invoke feelings of progress, optimism, and positive thinking. Show respect and affection for your audience, and under no circumstances use either foul language or ethnic slurs.
- Pay attention to your audience's nonverbal cues. You may need to adapt your presentation based on their reactions. Seeing people smile and lean forward indicates interest in what you are saying. Some in the audience may be easily distracted, so try changing the tone of your voice or making more eye contact to better reach them.

Self-Presentation

- SMILE! First impressions count. Nothing is more contagious than smiling — it can warm any room, not to mention ease your nervousness.
- Always maintain eye contact. Eye contact shows confidence and passion; but maintain it for no more than a few seconds before moving on to the next person.
- Be confident! You know your position is a good one; you know you have earned the right to talk about it, so show it! If you are nervous, use it. Try gesturing, palms up — this is a very inviting and open movement that others will respond to positively.

If you are the listener…Listen up!

It takes more than just speaking persuasively to be a good communicator.

Former Chief Justice John Marshall noted that "listening is as powerful a means of communication and influence as to talk well."[3]

Focus and be attentive

- Maintain eye contact with the speaker. This can help force you to pay attention and better focus on the speaker's position.
- Listen, don't hear! Hearing is an automatic response and does not require the absorption of information. Listening allows you to process information and use your critical thinking skills. Be dispassionate, though: try not to form an opposing argument or rebuttal while you're listening — perhaps there is a point you can agree with and build upon.

Be interactive

- Ask questions. The speaker will be expecting it, will be ready for it, and most importantly, often wants to be asked questions.
- Provide feedback after the speaker has finished. Interacting with the speaker in this way can develop into a very collaborative and meaningful exchange of ideas.

Pay attention to nonverbal cues

- React accordingly. If the speaker smiles, smile back if you feel it is appropriate. If the speaker presents you with the opportunity to interact with him or her, take the chance. It will show you are listening and are open to new ideas.
- Mirror their actions. If you agree with the speaker, let him or her know without actually vocalizing it: for instance, mirror the speaker's actions (e.g., smiling when they smile, using similar gestures, etc.).
- Be understanding and show respect, regardless of your point of view. Even if you don't agree with the position being presented, you should respect the individual — it takes a lot of guts to speak up about change. The speaker has invested time and energy into the proposal being offered — take it seriously.

Your communication style should reflect you as a person: play to your strengths, with respect to improving your weaknesses. But above all, remember that people respond well to ideas presented by speakers that are well-prepared, understand an audience's viewpoint, and respect different points of view.

Many publications, courses, and Web sites are devoted to public speaking and listening — here are some favorites:

www.toastmasters.org
www.dalecarnegie.com
www.nsaspeaker.org
www.public-speaking.org

References

1. Advanced Public Speaking Institute. (2005). Public speaking: How to relax for your talk. Retrieved March 30, 2006 from *www.public-speaking.org/public-speaking-relax-article.htm*
2.Turning a phrase. (1996, August 29). Newshour Analysis. [TVProgram]. Retrieved March 30, 2006 from *www.pbs.org*
3. Internal Listening Association. (2004). Quotation by John Marshall. Retrieved March 30, 2006 from *www.listen.org/quotations/quotes_effective.html*

Table 2: Shame and Communication & Openness Mean Scores* by Occupation (2000 vs 2005)

Occupation	Shame		Communication & Openness	
	2000	2005	2000	2005
All Staff	3.39 **	3.49	3.89 **	3.70
Diagnostic	3.38 **	3.45	3.94 **	3.74
Dietary/Food Service	3.47	3.57	3.82 **	3.67
Facilities Management	3.42	3.48	3.85 **	3.61
Administrative Services	3.45 **	3.53	3.83 **	3.68
Medical Staff	3.27	3.36	3.94 **	3.76
Resident Physician	2.98	3.25	3.59 **	3.49
Nursing	3.36 **	3.49	3.99 **	3.75
Pharmacy	3.31	3.34	3.82 **	3.70
Social Work	3.33 **	3.51	3.84 **	3.74
Other	3.46	3.51	3.86 **	3.66
Unknown	3.33 **	3.46	3.85 **	3.45

* Score of 5 "best"; score of 1 "worst"
** Statistically significant ($p<0.05$) difference between 05 & 00.

survey used questions covering 14 dimensions of patient safety (see Sidebar 1). In theory, the 14 dimensions encapsulate patient safety culture into its most important high-level components. Five were taken from an Agency for Healthcare Research and Quality (AHRQ) survey so that comparisons could be made to non-VA hospitals.

Two dimensions, "Communication & Openness" and "Shame," measured in both 2000 and 2005, may offer some insight into the penetration and impact that the VA patient safety program has had during the past five years.

Compared with the other dimensions, a change during 2000 to 2005 in these two dimensions is less likely explained by respondents' newly gained critical thinking about patient safety and more likely due to explicit efforts at VA to reverse lifelong reactions to shame and communication about errors.

Table 2 shows the average scores for questions contained in the "Shame" and "Communication & Openness" dimensions for both surveys. The average scores are reported by occupation of the respondents. Dimension scores can have a maximum score of 5 (best); a minimum of 1 (worst).

The table suggests the influence of the VA patient safety program's efforts to reduce the stigma of shame surrounding making "errors": Mean scores for "shame" were better in 2005 across all the reported occupation groups.

This reduced concern by staff towards "shame" or "blame" when reporting problems potentially improves the ability of a hospital to identify systems-based problems and find solutions to them. But this potential can only be realized when staff also believe that they can report and discuss their mistakes openly. The positive synergy of the dimensions "Shame" and "Communication & Openness" can enhance a facility's patient safety culture.

A lack of positive synergy between these two dimensions for VA as whole is reflected in Table 2. Note that all scores for "Communication & Openness" have declined since 2000, meaning that more staff, overall, believe that communication about patient safety issues is not as open as as it could be. Though this might be viewed as an absolute decrease in openness and communication in relation to the 2000 survey, it may well stem from a greater awareness of what is achievable from staff exposure to a wide range of VA patient safety initiatives.

Also, three of the seven questions in the dimension of "Communication & Openness" explicitly relate to supervisory trust and communication — and largely influenced the lower scores in 2005. (PSMs may wish to review questions 23, 26 and 27.) Improvement in "Communication & Openness," therefore, will require more effort from VA supervisors. One of the ways NCPS is attempting to improve communication and openness in critical care areas VA-wide is through Medical Team Training. Click to our web site to learn more: www.patientsafety.gov/mtt.

The VA 2005 culture survey also allows comparison to five dimension benchmarks established in a 2003 pilot survey conducted by AHRQ: The Hospital Survey on Patient Safety Culture. The pilot survey was completed by over 1,400 staff from 20 different hospitals across the nation.

The benchmark statistic is the percent of positive responses, defined as the number of questions answered positively in a dimension, divided by the number of non-missing responses. AHRQ provides a guideline for making comparisons: A "hospital's percentage should be at least 5% higher than the benchmark to be considered 'better,' and should be at least 5% lower to be considered 'lower' than the benchmark." (AHRQ 2006). For more information on the AHRQ survey, visit *www.ahrq.gov/qual/hospculture/*

The bar graph on page 1 shows a comparison between VA dimensions scores and five AHRQ benchmarks. In three of the dimensions, VA scores are shown to be "better" than the AHRQ. Scores for the other two dimensions indicate that VA is the same or similar to the hospitals surveyed by AHRQ: Teamwork within Hospital Units and Teamwork across Hospital Units.

The comparison between the AHRQ survey's benchmarks and our survey results are the most clear-cut indication of where VA stands in relation to the private sector; particularly encouraging are Dimensions 9 and 14 (see graph on page 1). The result indicates a greater willingness by VA staff to report safety issues, and, as we often say: "You can't fix what you don't know about." VA medical center employees can contact their patient safety managers for details on survey results specific to their facilities.

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