# VA National Center for Patient Safety

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NCPS
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VA HEALTH CARE
Defining EXCELLENCE in the 21st Century

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# VA National Center for Patient Safety

## First Do No Harm

The Department of Veterans Affairs (VA) National Center for Patient Safety (NCPS) was established in 1999 to lead VA's patient safety efforts and to develop and nurture a culture of safety throughout the Veterans Health Administration (VHA).

The primary goal of NCPS is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care.

## A National Team

NCPS' multi-disciplinary team is located in Ann Arbor, Mich., Wash., D.C., and White River Junction, Vt.

NCPS offers expertise on an array of patient safety and related health care issues.

Patient safety officers at VA's 21 regional health care systems and patient safety managers at 152 VA medical centers and other large facilities actively participate in the program.

## Veterans Health Administration

NCPS is part of the VHA, the largest integrated health care system in the nation.

The VHA serves the needs of America's Veterans by providing primary and specialized care, as well as related medical and social support services.

It supports innovation, empowerment, productivity and continuous improvement.

## Taking a "Systems Approach"

The NCPS program is based on a systems approach to problem solving that focuses on *prevention, not punishment.*

NCPS uses human factors engineering methods and applies ideas from "high reliability" organizations, such as aviation, to target and eliminate system vulnerabilities.

## Root Cause Analysis

NCPS uses a multi-disciplinary team approach, known as root cause analysis (RCA), to study adverse medical events and close calls (sometimes called "near misses").

The goal of each RCA is to find out *what happened, why it happened,* and *what must be done to prevent it from happening again.* Training programs, cognitive aids, and companion software have been developed by NCPS to support facility RCA teams.

Along similar lines, NCPS developed and implemented the Healthcare Failure Modes and Effect Analysis process and other tools for health care professionals to use in proactive risk assessment and prevention of harm.

## Confidential Reporting System

The NCPS Patient Safety Information System is an internal, confidential, and non-punitive reporting system.

It allows NCPS to electronically document and analyze patient safety information from across VA so that lessons learned can benefit all caregivers.

A systems approach to problem solving requires a willingness to report problems or potential problems so that solutions can be developed and implemented.

Following the implementation of our reporting system and other NCPS programs, NCPS saw a *30-fold* increase in event reporting and a *1,000-fold* increase in the conduct of RCAs, reflecting the level of commitment to the program by VA leaders and staff.

As of publication of this brochure, more than 19,150 RCA reports and 804,695 safety reports have been recorded in the system since NCPS was established 12 years ago.

Willingness and an avenue to report problems or potential problems is essential to safe care because *one can't fix what one doesn't know about.*

## Publications

NCPS publishes safety alerts and safety advisories on specific issues relating to equipment, medications and procedures that might cause harm to our patients.

Staff members have published more than 230 articles in external periodicals, such as *The Archives of Surgery, Emergency Medicine Journal,* and *The Journal of the American Medical Association.*

NCPS also publishes a bimonthly newsletter, *Topics in Patient Safety®(TIPS),* that discusses a wide range of patient safety issues. An archive of all *TIPS* issues, 2001 to present, is available on the NCPS Web site.

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# Program and Initiative Highlights

### Patient Safety Training

NCPS' inclusive patient safety training program has been attended by more than 2,500 VA caregivers at the 33 sessions conducted since November 1999.

Professionals from 285 domestic health care institutions or agencies have also attended, including representatives from the Department of Defense, the American College of Surgeons, and the University of Michigan.

Internationally, we have trained representatives from 12 foreign nations, including Denmark and Australia, which subsequently implemented national programs based on the VA model.

### Medical Team Training

NCPS developed this program to improve patient care outcomes through more effective communication and teamwork among providers. Since March 2005, we have facilitated 217 interactive "Learning Sessions" that involved more than 15,470 VA caregivers nationwide.

A VA study published in 2010 indicated an almost 50 percent greater decrease in the annual surgical mortality rate in groups instructed in Medical Team Training methods, as opposed to untrained groups. It was also noted that the longer these methods have been practiced at a medical facility, the greater the decrease in mortality.

### Tool Kits and Cognitive Aids

NCPS has developed a number of tool kits and cognitive aids, available on our Web site, that promote the development of a culture of safety, such as the multimedia "Falls Toolkit" and the "Escape and Elopement Management" cognitive aid.

### Patient Safety Directives

NCPS has collaborated with other VA offices to develop directives that provide specific guidelines for patient care, such as "Ensuring Correct Surgery" and "Adverse Drug Event Reporting."

### Mental Health Environment of Care Checklist

The checklist was developed for VA medical facilities to review inpatient mental health units for environmental hazards, decreasing the chance a patient could commit suicide or inflict self-harm.

In a 2010 VA study that examined the effectiveness of a standardized checklist for mental health units, a survey of 113 VA facilities indicated that they were able to reduce the risks associated with 5,834 (76 percent) of the identified hazards.

### The Daily Plan®

This initiative enhances patient safety by involving patients in their care. A single document is provided to them that outlines what can be expected on a specific day of hospitalization.

A facility can customize the document and include a number of items relevant to care, such as: medications, nutrition and allergies.

### Patient Safety Centers of Inquiry

NCPS manages the centers, which are an integral part of our program.

The centers develop, disseminate, and, most importantly, implement clinically relevant innovations that can improve patient safety at VA medical facilities.

A recent example is the creation of a comprehensive moderate sedation toolkit for non-anesthesiologists.

### Patient Safety Curriculum

NCPS believes the place to begin learning about patient safety is during early training.

In 2002, NCPS began working with physicians and patient safety personnel from VA medical centers and affiliated universities to develop and test a patient safety curriculum program for residents.

From this, NCPS created faculty development workshops. Over 1,000 have attended these from more than 100 VA medical centers and 50 university affiliates, to include professionals from 42 states and six foreign countries.

NCPS has also developed a three-year series of workshops for residents that include: patient safety basics, human factors engineering, and simulation-based teamwork and communication.

### Patient Safety Culture Survey

NCPS performs a national survey every three to five years to measure changes in the patient safety culture: A combined total of more than 105,350 VA employees participated in the 2000, 2005 and 2009 surveys; another was conducted in 2011.

The results have included important developments, such as a significant improvement in senior management's awareness and support for actions that promote patient safety.

### Patient Safety Assessment Tool (PSAT)

This Web-based assessment tool allows managers and staff to conduct a detailed assessment of the patient safety program using Joint Commission standards and industry best practices. PSAT provides sections for leadership rounds focusing on the patient care environment and now has a feature that allows for tracking issues through to completion.

## Information Technology

NCPS championed creation of the Bar Code Resource Office and the Informatics Patient Safety Office. NCPS continues to partner with both offices to promote use of human factors engineering design principles in software and other information technologies.

As VA redefines excellence in the 21st century, NCPS is playing an integral part in a number of informatics initiatives, such as redesign of VA's pioneering electronic health record system.

Staff members are also working to secure prioritization of numerous other patient safety information technology projects.

## NCPS Pharmacists

NCPS pharmacists support VA medical center compliance with Joint Commission National Patient Safety Goals, to include accurate and complete reconciliation of a patient's medications across the continuum of care.

They recently conducted a national effort to develop a single standardized prescription label for use within VA, directly involving Veterans in the process.

The goal is to determine how best to serve the VA's 4.4 million pharmacy users through the redesign of labels affixed to nearly 122 million prescriptions dispensed each year.

## Product Recall Office

Located within NCPS, VA's Product Recall Office is tasked to manage recalls of all medical devices and products initiated by manufacturers or the FDA that are applicable to VA.

Following its December 2008 establishment at NCPS, recalls compliance – removing recalled products from the supply chain – has risen to and is holding at 98 percent.

The Recall Office receives more than 12,500 recall notices from a variety of sources annually.

## Patient Safety Fellowships

The VA Office of Academic Affiliations (OAA) teamed with us to offer one-year fellowships in patient safety. NCPS manages the program; OAA provides the funding.

Thirty-six have been selected as fellows since the program began in 2007, 36 have been selected as fellows. Projects have included: evaluation of falls injuries and prevention strategies; curriculum for physician assistants.

## Cornerstone Recognition Program

The program began in fiscal year 2008 to incentivize VA facilities to complete more timely RCAs, focused on a systems-based approach.

The number of award recipients has increased from 71 in 2008 to 123 in 2011.

## Clinical Crew Resource Management

Aimed at front-line nurses in VA, this program is based on techniques developed in aviation that mitigate error through the effective use of all available resources in operational decision making: information, equipment, and people.

Fourteen nursing units in nine VA facilities received training as part of the initial pilot, which included a six-hour learning session and two-hour clinical simulations, using high-fidelity patient simulators.


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