

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION

The VA Lessons Learned Project:

Part of an Institutional Strategy for Enhancing Patient Safety and Reducing Health Care Errors

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AND COLLEAGUES

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The Veterans Health Administration (VHA) has joined the national patient safety movement in the United States, implementing a number of initiatives including:

- establishing a Patient Safety Office;
- providing competitive funding for Patient Safety Centers of Inquiry; and
- building a sentinel event registry.

One of the important steps was to establish a mechanism for learning from experience, as well as sharing and generalizing new innovations aimed at improving patient safety. That mechanism, the VA Lessons Learned Project, promises to be an important ingredient of the quest to improve patient safety.

Health care institutions and organizations face common patient safety issues, such as falls, medication errors, wrong site surgery, elopement (leaving a hospital without authorization), assaults, and restraint deaths. In many instances, one facility may have found a solution to a particular problem, while other centers are left struggling with the same dilemma. Until recently the VHA had no systematic method capitalizing on the problem-solving experiences and knowledge of its vast enterprise. If one medical center improved a patient safety process and avoided risk, there was no simple way for the other 172 medical centers and 600 community clinics to adapt this information to their settings.

The VA Lessons Learned Project is a knowledge-management tool for fast-cycle collection, evaluation and dissemination of lessons learned from successes and errors throughout the system. It is based on non-punitive analysis of past experience, resulting in implementation of system redesigns to improve future performance. A safe forum for health care providers to anonymously report incidents is essential for fruitful dialogue and improvements. A key component of the Lessons Learned initiative is dedicated to patient safety. It provides a systematic mechanism for sharing lessons learned from errors, with the aim that mistakes should occur only once.

The project is the brainchild of Thomas L. Garthwaite, MD, the VHA's Acting Under Secretary. In 1996, he realized that

medical centers in the VHA had knowledge that could be more effectively shared across and beyond their own walls. The sharing of solutions, innovations, and best practices could only save resources—and in many instances, heartaches.

'The VA Lessons Learned Project is a knowledge-management tool for fast-cycle collection, evaluation and dissemination of lessons learned from successes and errors throughout the system.'

The goal of the Lessons Learned Project is to establish behaviors and infrastructure that promote:

1. Rapid sharing and adoption of innovations, successes, and solutions to problems throughout the VA;
2. Sharing lessons learned from mistakes and failures, so a single mistake anywhere in the system leads to improvement in the entire system.
3. Sharing problems as they are identified, so solutions generated at other sites can be applied quickly.
4. Matching problems to experts from around the system to speed and enhance solutions.

The conceptual framework of the VHA Lessons Learned Project was developed by exploring two bodies of literature:

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The VA Lessons Learned Project

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lessons learned/best practices, and communities of practice. The infant project was benchmarked in 1997 with the Center for Army Lessons Learned, the Navy Acquisition Reform Office, the IRS, the Army AMEDD and EDS, Inc.'s Virtual Communities of Practice. Face-to-face and electronic comparisons and references offered VHA a springboard for developing this knowledge management tool. The VA Intranet served as the main vehicle to disseminate lessons and encourage implementation of new ideas within the agency. The web site of the Lessons Learned Project was labeled the Virtual Learning Center (VLC).

personal profile by selecting key words of interest. Whenever a new idea is posted to the VLC in those areas, users are automatically notified by an e-mail message with a hot link to the "lesson" containing the idea.

The VLC acts both as a repository for easily searchable information and a place where VHA employees can go to seek answers from knowledgeable colleagues. It allows users to submit, browse, search, certify implementation and discuss lessons based on innovations and successes. The VLC provides a national forum for engaging colleagues in dialogues through various interactive forums, chat rooms and virtual Communities of Practice.

The Patient Safety component of the VLC carries lessons learned from innovations, as well as adverse events occurring in both VA and non-VA health care systems. Lessons based on adverse events expand on the elements in their format that are of particular relevance, such as root cause analyses and system redesigns. It also carries sentinel event and faulty product alerts and links to patient safety resources on the World Wide Web.

The VLC was activated in December 1997. To date, about 730 lessons are posted on its Intranet site, 67 of which pertain to patient safety; approximately 14 of these are available on the VLC web site, with more to come. These lessons have received approximately 50,000 online hits. Lessons can be searched by subject matter (through a keyword list), author name, source facility, date, and other variables.

The VLC is now equipped to support Patient Safety Communities of Practice (PS-COPs) which allow discussion of patient safety issues such as restraint deaths, adverse drug events, patient elopements, patient suicides, and scaldings. Discussions will include sharing incident narratives, analysis, sharing solutions, identifying best practices, etc. Some of the identified best practices may be adapted into VA policy.

'The Patient Safety component of the VLC carries lessons learned from innovations, as well as adverse events occurring in both VA and non-VA health care systems.'

"Customer input" was sought by convening a meeting of 50 national VHA leaders to help determine the parameters of this embryonic knowledge management device. They focused on the proposed web site and established a few guidelines, including: easy access; just-in-time, one-stop availability of knowledge; user-friendliness; relevance to daily work situations; and optional anonymity for participants. The VLC quickly became a resource for sharing innovations, lessons learned, and safety initiatives. More recently, a sister VLC site was opened on the Internet, which carries most of the information in the Intranet site. For security and legal reasons, some of the patient safety lessons based on adverse events are posted only on the Intranet site.

The VLC offers a number of features to help users submit, browse, search, and discuss lessons. These include descriptions of innovative VHA clinical or administrative initiatives, VHA Clinical Programs of Excellence, other award-winning programs, as well as raw ideas. Lessons posted follow a simple universal format including: title, author(s) information, core message, need/rationale/incident report, proximate causes, root cause analysis and system redesigns, and measured or anticipated outcomes. Users can also create a

Visit the Virtual Learning Center

Health care professionals from VA and non-VA facilities and organizations are invited to visit and use the services of the Lessons Learned Project's Virtual Learning Center (VLC).

The web site can be accessed at www.va.gov/vlc

The ABCs of Patient Safety

BY DONI HAAS, RN AND LORRI ZIPPERER, MA

Doni Haas, RN is a health care risk manager in Stuart, FL and a member of the NPSF board.

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Accountability is not always about a person.

Blame hides the truth about error.

Cultures must change.

Document facts.

Error is our chance to see weakness in our systems and people.

Focus on prevention.

Gather evidence to support facts.

Hear when you listen.

Investigate cause.

Justice should include compassion, disclosure and compensation.

Knowledge must be shared.

Learning from others' mistakes benefits all.

Make the effort to look beyond the obvious.

Nothing will change until you change it.

Opportunities for solutions are lost by blame.

Partner with patients and practitioners.

Question until you can no longer ask "why?"

Reporting error is suppressed by blame.

Systems are where practitioners practice.

Think about the blunt and sharp end.

Understand the role of accountability.

Value the patient's perspective.

Why, Why, Why, Why, Why = root cause.

X-ray vision sees the deeper story.

You can make a difference.

Zeroing in on cause brings us one error closer to zero error.

Can the Media Be Your Partner in Promoting Patient Safety?

BY LARRY TYE, HEALTH REPORTER, *BOSTON GLOBE*

commentary

In March 1999, the *Boston Globe* published health reporter Larry Tye's four-part series, "Patients at Risk," about medical errors in hospitals and steps being taken to reduce them. Mr. Tye was a featured speaker at the July 15, 1999 policy forum on patient safety in Washington, D.C., convened by NPSF, the American Hospital Association and the Joint Commission for Accreditation of Healthcare Organizations. The following segment is based on his comments from that event.

The whole idea of the press and the medical establishment partnering on anything—even something as worthwhile as keeping patients alive and healthy—makes me a bit uncomfortable.

Like most reporters, I grew up thinking that unless you keep a healthy distance from your sources, you'll be compromised. And like most medical writers, I presumed that what's best for doctors, insurers, and other powerful players in the medical world isn't always what's best for your patients and our readers.

But my skepticism is nothing next to yours. To health care professionals, I imagine, the idea of reporters as friends or—God forbid—as collaborators, is as much an oxymoron as the notion of "jumbo shrimp" or "fresh frozen." Reporters like me should be humored or, even better, avoided. When you can't do that, you should treat us with care, always assuming we won't get things quite right, and will seek to glamorize or dramatize whatever story we're telling. That's especially true, you probably think, when the topic is the highly sensitive and highly litigious one of medical errors.

Enough about our mutual fears and loathings. What I'd like to do is tell you how, in a recent series on medical errors I wrote for the *Boston Globe*, I managed to work with my sources—although we never became "partners"—in producing a project I hope was true to my journalistic standards and fair to my sources—and most importantly, that promoted patient safety.

I knew most everyone in the medical world would be wary about a series on hospital errors, even when I tried to make it a bit more palatable by pointing out that it really

was about promoting patient safety. So my editors and I did several things to try to get around the problem. First, we were up-front about warning people that while we would talk about solutions to the problem, we'd have to begin by explaining what the problem is. This meant talking about real patients who had been injured or killed by actual doctors and nurses at real hospitals.

It also meant naming names, since that was the only way readers would believe us. Telling them all that made some sources more nervous, of course, but it also let them know up-front what we were up to, which seemed to build trust.

Second, when we found out about real problems at hospitals—and we came up with hundreds of them, all of which had been investigated by the state and substantiated as to the errors made and who made them—we gave the hospitals a chance to respond. They could tell us the context of the errors, or dispute the state's charges, or say anything they wanted in writing or in person. I sent out more than 50 faxes to hospitals across Massachusetts and, once the PR person who got them got over the shock, most took us up on our offer for input. They'd actually been warned by the Massachusetts Hospital Association to expect our faxes, and encouraged to cooperate after checking with their lawyers. And you'd be amazed—or at least I was—at how cooperative the hospitals were in "fessing up" to their mistakes and making top medical and administrative staffers available to answer my questions.

Third, we promised to look at all the reasons why medical errors happen—from the systemic issues to the resource ones. And I think we kept that promise. All of this made the enterprise not just another sensationalized look at hospital screw-ups, but a more rigorous and responsible look at why things go wrong, how widespread such mishaps are, and how errors can be rooted out of the system.

Hospitals, of course, liked that approach. And even more, they liked the fact that they weren't being singled out as an example of messing up. It took some of the sting out of their horror story by including so many other horror stories and showing the pattern of mistakes nationwide.

If it were just horror stories we were after, I could have written one a day for nearly a year—most of which would have been dramatic enough to have made the front page. There was, for example, the blind, deaf, developmentally disabled patient at a Northampton hospital who had a heart attack and died after being fed through an IV line in her shoulder rather than the feeding tube in her stomach—and the 79-year-old chemist from Winthrop who went into a coma and later died after doctors at a big Boston hospital treated him for a stroke when he really was having an insulin reaction.

Those and other bad-news tales were covered in the first two days of the four-day series. Part of day two, and all of the remainder of the series, were devoted to looking at underlying issues and how to redress them.

We also worked in constructive cooperation with health care agencies and institutions. The paper was willing to send me across the country to meet with senior staff at the NPSF, the Joint Commission, the AMA, and at hospitals from Salt Lake City to Philadelphia. And people at those institutions were willing to open up their records enough to let me really understand how they worked and how they were trying to work better.

I spent two days shadowing Joint Commission inspectors surveying a hospital in Rhode Island, checked out safety systems installed at Latter Day Saints Hospital in Utah, and talked to doctors, nurses and patients about whether they work the way they're supposed to. I talked to lots of people that health care professionals don't particularly trust—like malpractice lawyers and public-interest advocates—hearing their tales of woe, then cross-checking them with those at whom they were pointing the finger.

The national groups were incredibly cooperative, with only a few exceptions. And the ones in Massachusetts were even better, largely because Massachusetts hospitals, doctors and regulars already have forged a highly unusual partnership to root out medical errors. If you'll permit me a bit of parochialism, I think the Bay State's Coalition for the Prevention of Medical Errors should be a national model, and probably already is.

'There isn't any other issue I can think of in the medical arena where health care professionals and the reporters who cover them are in as clear-cut agreement as with the need to improve patient safety.'

Reporters are going to write stories on medical errors with or without your cooperation, and helping us to put these errors in context is a much better way to go than simply wishing we'd go away. The more you try to avoid us, the more we'll think you have something to hide—and the more you can be assured that what could have been a one- or two-day story will play out, in print and on TV and radio, for many days more.

All reporters aren't created equal. If you don't have a local or national medical reporter whom you can trust, you should find one. And when you do, make sure you go to him or her with your story, be it good news—or, more to the point, when it's bad news. You can work with the reporter to tell the story fairly, with context, and be assured that when other media pick it up, it will be the full story rather than the partial one they might have told.

My series is over, but the story I was trying to tell isn't. I plan to do one or more follow-up stories on what, if any, progress is being made on patient safety in Massachusetts and across the country. There isn't any other issue I can think of in the medical arena where health care professionals and the reporters who cover them are in as clear-cut agreement as with the need to improve patient safety. If you really want to get your message out—to doctors and nurses, insurers and patients—you should try to work with us in the media.

Tye, L. "Patients at Risk: A Four-Part Series." Boston Globe 1999. The four articles in this series include:

- 1) Families' tragedies reveal flaws in medical systems, 3/14/99;*
- 2) Mistakes plaguing systems; errors at hospitals can prove deadly, 3/15/99;*
- 3) Review system for hospitals is ailing, 3/16/99; and*
- 4) Seeking a prescription against mistakes, 3/17/99.*

Communicating with Patients About Risk and Safety

BY FIONA TITO, ENDURING SOLUTIONS PTY. LTD, WANNIASSA, AUSTRALIA

commentary

As chair of the Australian Government's Review of Professional Indemnity Arrangements for Health Care Professionals between 1991 and 1995, Fiona Tito got to see "the inside story" of Australia's national research on adverse events in health care. She is also the drafter of the Australian Capital Territory's Patient Safety Action Plan.

In a recent visit to the US, Ms. Tito discussed patient safety and communication issues with the NPSF staff, and Lorri Zipperer asked her to write about some of the lessons she has learned for readers of Focus.

The first confession I have to make is that I am not a health professional. I still call the large expanse below my waistline "my stomach" with total clinical inaccuracy. I still get confused about which "end" the various "oscopies" go into.

My second confession is that I have dealt with more health professionals than your average patient—as a patient, caregiver and policy maker. I have a so-called "chronic condition" which means I have seen lots of health professionals over my four decades. My mother and I nursed my father at home a couple of years ago as he died from stomach cancer.

When asked for my advice about patient safety and communication, I decided to offer three simple guidelines, even though they are experientially based rather than backed by meta-analyses or even a single randomized control trial.

1. Patients usually want to know more than you think, particularly about risks and safety issues, so don't assume we won't understand or don't want to know.

My theory about risk disclosure in health care is that clinician comfort increases to the point where information given ensures the patient agrees with the clinician. Thereafter, it decreases as the patient knows enough to make his or her own decision. Recent Australian analysis shows that, as far as risk of death per hour of exposure is concerned, being in an Australian acute care hospital is

'Patients usually want to know more than you think, particularly about risks and safety issues ...'

about 400 times more dangerous than flying in a commercial aircraft and only five times safer than parachuting. That's before you get started with any of the really risky stuff! The fact that some patients will say "I don't want that treatment" once they know the risks is a GOOD thing. The long-heralded partnership between doctors and patients must be characterized by this respect for self-determination or it is not a partnership at all.

Don't judge what patients want to know about risk and safety by how we respond immediately after you tell us life-shattering news. When you tell us bad news, our hearing initially gets very focused. It goes something like this—"Well Jane, the test results aren't good Blah Blah Blah cancer Blah Blah malignant Blah Blah"—you get the idea. Think about what you hear when someone phones you and says "Well, doctor, I am really unhappy with what you did to me Blah Blah lawsuit Blah Blah malpractice Blah lawyer Blah Blah." It's the same process for patients.

Once the bad news has sunk in, most patients want to know a lot of things. Often it's stuff you might either take for granted (like "How will the medicine get into me?") or won't know for sure (like "How fast is it growing?"). Most of us will assume if it's cancer, that it is growing faster than the dump off New York City, and that if it is not treated today, we will be dead by Monday.

People need to be told when they have time to think through their options and the risks associated with them without adversely affecting the outcome of their disease. The treating team then needs to ensure that the person has lots of opportunity to ask more questions. As the

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Prescription Instructions: Opportunities for Healing, Potential for Harm

BY HELEN ALTMAN KLEIN, PhD

While progress is being made in understanding medical errors in hospital settings, medication errors don't happen only in hospitals. Much less attention has been given to the less visible problem of errors in self-administered prescription drugs. The laboratory at Wright State University has been looking at these medication patterns. What has been found has sometimes been comical and sometimes troubling. To reap the benefits of modern medications, users must follow storage recommendations, schedules, and dosages. They may have to avoid some foods, alcohol, or specific medications and also must monitor, evaluate, and respond to warning signs. Wright State University researchers found that the information sheets many pharmacies distribute to patients are often poorly written and formatted. Using Human Factors principles, the researchers were able to implement significant improvements, but this is not enough. It is time to review the whole process of medication use and comprehension with an eye toward providing user-friendly instructions that will reduce dangerous misunderstandings and errors.

Most pharmacies now provide commercially available information sheets with prescriptions. While these contain information for safe, effective administration, not all people find them useful. Many sheets have readability scores far exceeding the recommended 8th grade level. Some were difficult to visually scan and included confusing terminology. When information sheets are hard to read and understand, compliance suffers. Human factors research related to interface design, information processing, and perception provided guidelines for revising information sheets. The researchers developed patient-friendly sheets using simpler language to make the information easier to understand, and reformatted the information to maximize the usefulness of the organizational structure. The goal: to optimize understanding of written instructions to facilitate correct medication use.

Did these changes make a difference? The researchers compared commercially available information sheets with these

human-factored sheets. They first interviewed 62 people age 18 to 30, asking critical questions about the medication while participants could reference each sheet. The researchers found that patients could read and find information much more quickly and more accurately from the human-factored sheets, which the participants overwhelmingly preferred. Then they interviewed 42 people age 58 to 87, with similar results. The older participants strongly preferred the human factored version. Finally, 39 pharmacy customers age 19 to 59 were given both the pharmacy's usual information sheet and the human-factored version with their prescription. One week later, participants were queried about sheet preferences, usage, and basic medicine information. They strongly preferred the human-factored sheets to the commercially available sheets.

The researchers found, however, that this rewriting was not enough. While most participants used information sheets to some degree, they identified some troublesome limitations and recurring misunderstandings. The research suggests that many users want—but do not receive—information regarding interactions with medicines and foods. The researchers identified several areas of potentially dangerous misconceptions. Participants, for example, often misunderstood what constitutes a serious side effect. They sometimes discounted appropriate medication storage. These misconceptions show that even with clearer, easier-to-read sheets, more needs to be done to help patients understand and use critical information.

A study under way at Wright State, led by Judith J. Isaacson, is using process-tracing interviews with prescription users to learn how patients actually understand and use prescription medications. Designing information to maximize medication effectiveness and minimize errors depends on having a clear picture of how users conceptualize medication use. Medical errors in the home must not be ignored, even though they are harder to delineate and control than those in hospital settings. Human factors can be useful in meeting this challenge.

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The opinions expressed in this publication are not necessarily those of the National Patient Safety Foundation or of its board of directors.

To submit articles to, or publications for possible review in, Focus, please direct materials to: Lorri Zipperer, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation at the AMA, 515 N. State Street, Chicago, Illinois 60610. Materials, inquiries and subscription requests for the publication will be accepted electronically at npsf@ama-assn.org or via fax at 312-464-4154.

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patient's level of knowledge and understanding grows, real partnerships in care can happen.

2. Use diagrams and any communication tools you can. Patients all learn differently; often speaking at us (or worse, down to us) may not be the most effective way to communicate about patient safety issues.

The reality of any "risk" is hard for anyone to grasp—no doubt this explains the continuing popularity of gambling! From my observations about doctors and the "risk" of litigation, clinician understanding of the concept of risk is as poor as that of any consumer.

Diagrams, pamphlets, videos, and consumer guidelines are all useful ways to help patients understand patient safety issues. Clinicians are sometimes concerned that if a patient knows there is a remote risk of death from something such as an anesthetic, that they will always refuse treatment. This underestimates the level of sophistication of most consumers. Refusing to undergo a procedure can be a sensible result of our own personal risk-rating process. I have heard clinicians argue that it may be ethical to lie to people in some cultural groups, who are so afraid of hospitals that they would prefer to die of their condition than face hospital admission. Such a view is

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immensely disempowering and shows a depressing ignorance about a patient's right of self-determination.

3. Be a good listener—be patient and respectful.

Patients will often weigh concerns differently than a clinician. Part of effective communication is to really listen to patient concerns. Sometimes these concerns may be based on a lack of understanding or misinformation. A clinician who is listening respectfully can provide additional information to clarify these issues. When a patient's concerns are cultural or individual, a clinician sometimes needs to understand this and abide by the patient's wishes, even if the clinician disagrees with them.

The value most people attribute to certain risks and to patient safety issues will vary over time. Something a patient may consider too unsafe or risky at one time may not be so at a different time, because the factors they are weighing may have changed. For example, I don't undertake too many hazardous leisure activities at the moment, because I am a single parent with two young kids. However, when I am 10 years older and the kids are grown, I might well take up something I consider risky but otherwise pleasurable. Meanwhile, it's back to the patchwork and reading for me.

