Stanford MEDICINE
Health Care

Quality Improvement and Patient Safety

Providing Safe, Effective, Patient Centered, Timely and Equitable Patient Care

Stanford MEDICINE
Health Care

Topic 3. Patient Safety

Introduction

Learning Objectives

When you complete this 20-minute online course, you will be able to:

- State the SHC's quality improvement approach
- Describe SHC's Ever Ready program and the Joint Commission's National Patient Safety Goals
- Identify the Stanford Alerts for Events (SAFE) reporting system

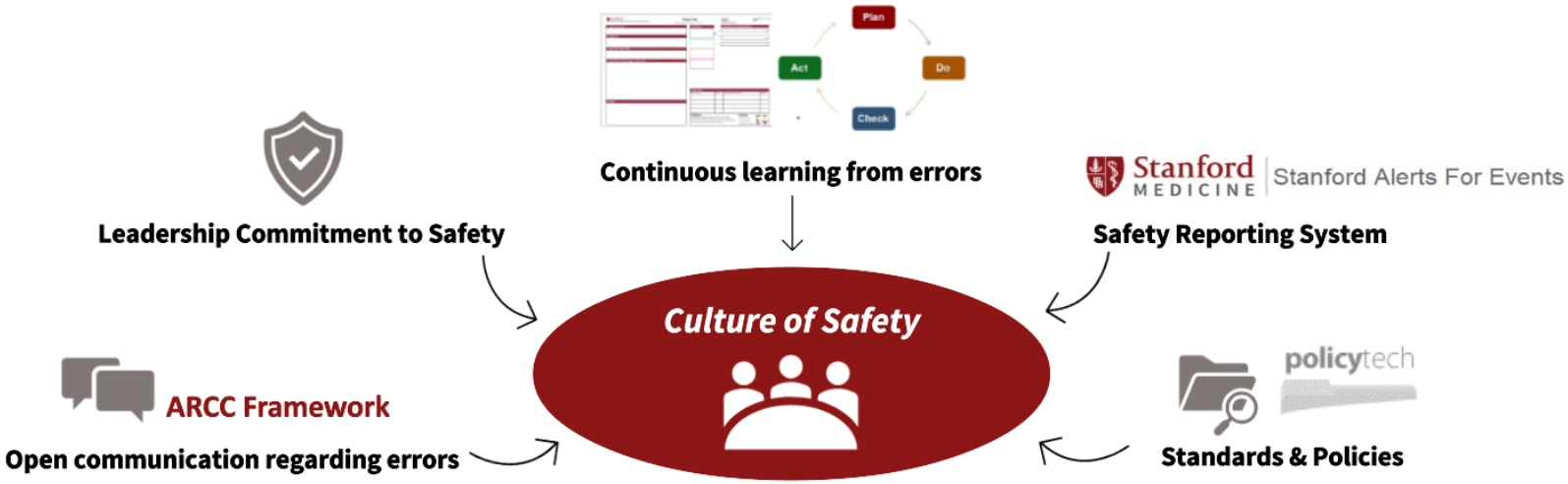
Learning Objectives

When you complete this 20-minute online course you will understand:

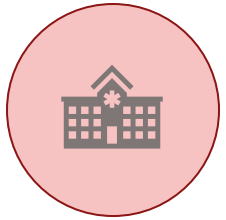
- How SHC fosters a Culture of Safety that supports the delivery of safe, high-quality care.
- The systems and processes in place to support Patient Safety at SHC
- Accreditation/Regulatory Compliance, Survey Readiness, & National Patient Safety Goals

SHC aims to create a Culture of Safety that supports the delivery of safe, high-quality care.

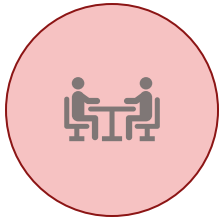
Culture is the set of shared attitudes, behaviors, values, goals, and practices that **characterizes an organization**.



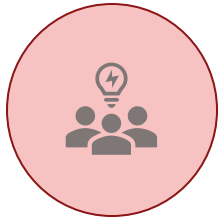
When teams develop a strong culture of safety, it may look and sounds like...



" I WOULD FEEL SAFE BEING TREATED HERE AS A PATIENT."

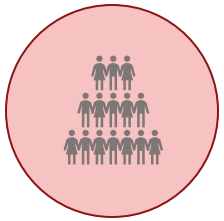


"WE ARE OPEN TO DISCUSSING ERRORS AND TAKE THE OPPORTUNITY TO LEARN FROM THEM."

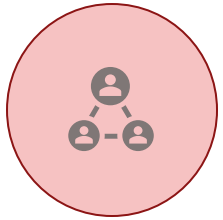


"MY SUGGESTIONS ABOUT QUALITY WOULD BE ACTED UPON IF I EXPRESSED THEM TO MY LEADERS."

"IT IS EASY FOR ME TO SPEAK UP IF I PERCEIVE A PROBLEM WITH PATIENT CARE."



"DIFFERENT DISCIPLINES WORK TOGETHER AS A WELL-COORDINATED TEAM."



" OUR TEAM SHARES THE SAME VALUES AND PRIORITIES AS SHC'S LEADERS."

The ability for any team member to speak up and express a concern is a key to creating a strong safety culture

- **ARCC is the Stanford Medicine Framework for Voicing Safety Concerns**
- **ARCC provides a common framework and language to communicate with each other when a potential safety incident might occur**

ARCC in Practice

- **Ask** a question to open dialogue about your concern (introduce yourself first if applicable)

- *"Did we complete the time-out for this procedure?"*

It's fine. We did it while walking to the room.

- **Request** a change that would address your concern (and explain why if applicable)

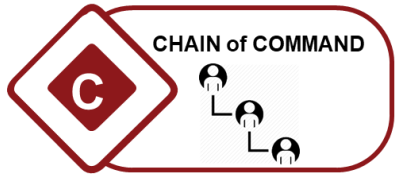
- *"Before we proceed, could you please complete the time-out so we can ensure everything is correct?*

You're new here, aren't you? I told you already, it's fine.

- Voice your **Concern** ("I am concerned…", "I am uncomfortable…")

- *"I am concerned that we have not done an appropriate time-out for this procedure, and I am uncomfortable with proceeding."*

Well, I am not concerned. We're doing the procedure now.



- Finally, use the **Chain of command** if you cannot reach consensus ("This is a safety issue. Please stop.")

- *"This is a safety issue. Please stop so we can discuss the situation with the unit manager and medical director."*

Why does ARCC work?

ARCC IS A NON-THREATENING FRAMEWORK TO SPEAK UP WHEN THERE IS A SAFETY CONCERN

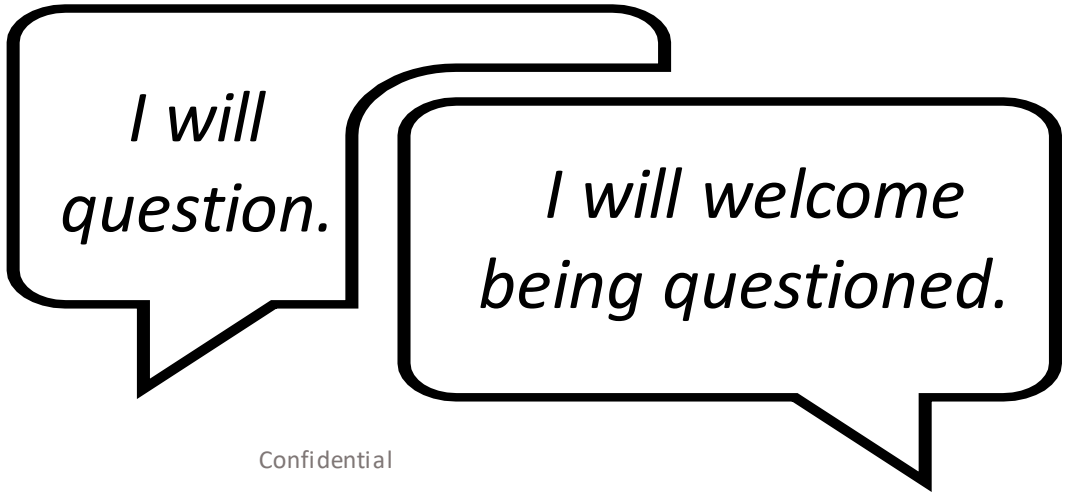
ASSUMES THE GOOD INTENT OF YOUR COLLEAGUES

LEVELS THE POWER DIFFERENTIAL; FLATTENS HIERARCHY PERCEPTIONS

SETS THE EXPECTATION OF ESCALATING WHEN CONCERNS ARE NOT ADDRESSED

GIVES US A SHARED LANGUAGE

We all commit to fostering a culture open to questioning.



Systems & Processes to Support Patient Safety

The work we do is profoundly important and our patient's lives depend on it. At the same time, our systems are complex and there is high potential for error in our work.

It is essential that we acknowledge the risks and learn from actual or potential errors to prevent future harm.

To make improvements and prevent patient harm we rely on our teams to report all safety concerns.

- **SAFE** is the system to report occurrences that may have safety, quality of care or risk management considerations and may require further follow-up from our teams. It is a protected system for all patient safety events and data. We rely on all SHC staff, clinical and non-clinical, to submit safety concerns.

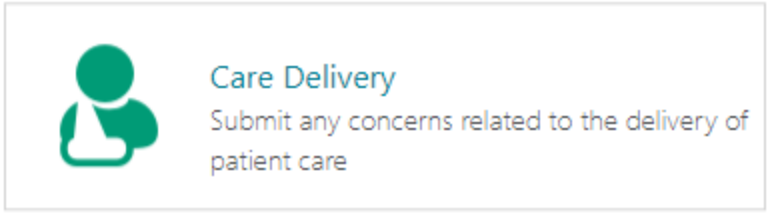
- **Everyone is responsible** for reporting safety concerns even if they did not impact a patient. This enables us to learn and make improvements to prevent future harm.

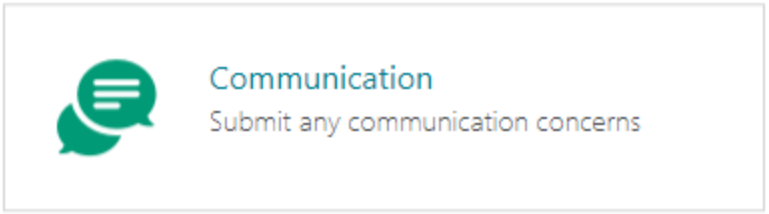
- If you are concerned that something is a serious event, or suspect that a patient has been harmed you must do the following:

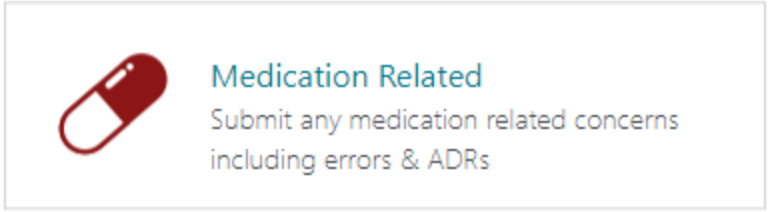
  - ❑ Notify your direct supervisor
  - ❑ Call Risk Management
  - ❑ Submit an event report via the SAFE reporting system

Examples of Safety Related Concerns & Events

Click on each category for examples







Safety is a top priority at Stanford Medicine Health Care. Our Executive Team endorses a blame free (non-punitive) culture so that employees and physicians feel empowered and safe to report all safety concerns.

Every SAFE that is reported is reviewed and actions are taken to improve our systems and processes.

Please select the option that best describes your role

Patient Facing

Non-Patient Facing

SAFE Submission for Patient Facing Staff – Via Epic

Patient Facing

- SAFE Reports can be submitted via Epic
- When launched through Epic, patient data will auto-fill the SAFE form. Complete the SAFE form and submit.

- For more information, please visit the resource page on SHC connect: https://stanfordhealthcare.sharepoint.com/:u:/r/sites/Safe_SHC/SitePages/default.aspx?csf=1&web=1&e=RZtZjE

- Informatics Education - Epic: Access the SAFE Patient Safety Reporting System via Epic (SHC/SHC-TV/SMP) (service-now.com)

SAFE Submission Via SHC Connect

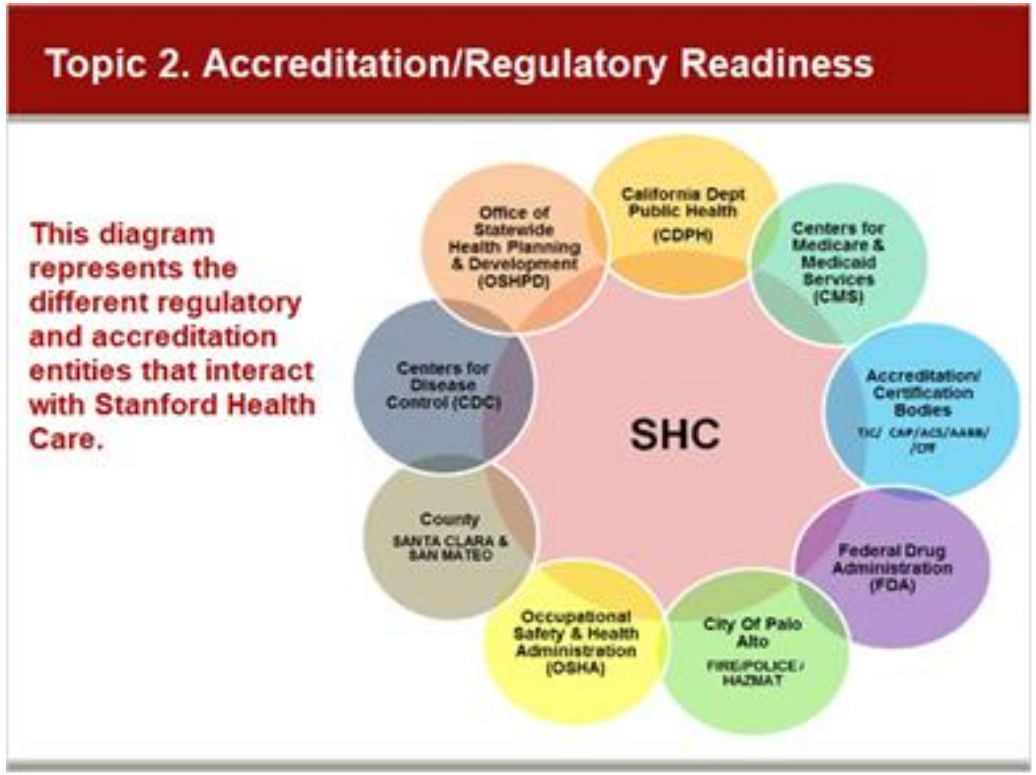
Patient Facing

- SAFE Reports can be submitted via SHC Connect, Select the "SAFE Reporting Portal" link on SHC Connect

- For more information, please visit the resource page on SHC connect: https://stanfordhealthcare.sharepoint.com/:u:/r/sites/Safe_SHC/SitePages/default.aspx?csf=1&web=1&e=RZtZjE

Topic 3. Accreditation/Regulatory Compliance, Survey Readiness, & National Patient Safety Goals

Accreditation/Regulatory Compliance & Survey Readiness



Topic 2. Accreditation/Regulatory Compliance, Survey Readiness, & National Patient Safety Goals

Stanford Medicine Health Care's Survey Readiness Program

1. Continuous Regulatory Readiness Committee
2. Chapter/section leaders and workgroups/committees
3. External and internal consultant mock surveys and patient tracers
4. Unit/clinic/department execution rounds
5. Education programs – in-services, huddles, and tip sheets
6. Quality & Leadership meetings
7. Training – Survey support roles (escorts, scribes, and liaisons)

Topic 2. Accreditation/Regulatory Compliance, Survey Readiness, & National Patient Safety Goals

The National Patient Safety Goals (NPSGs) were established by the Joint Commission (TJC) in 2002 to help accredited organizations address specific areas of concern regarding patient safety

The Joint Commission determines the highest priority patient safety issues, including NPSGs, from input from practitioners, provider organizations, purchasers, consumer groups, and other stakeholders

Examples of goals:
Identify patients correctly, Improve staff communication, Use medicines safely, Use alarms safely, Prevent infection, Identify patient safety risks, Improve health care equity, Prevent mistakes in surgery

For more up to date information about The National Patient Safety Goals, please visit [National Patient Safety Goals | The Joint Commission]

For questions, please contact RegulatoryAffairs@stanfordhealthcare.org

[CAN WE INCLUDE A KNOWLEDGE CHECK]

Acknowledge button: I am committed to sharing safety concerns and offering suggestions for improvement