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SPECIAL FEATURE

Everyone Has a Responsibility for Patient Safety, Part III: The Institution's Role

This article is the third installment in a three-part series on the roles patients, health care professionals and institutions play in patient safety in the health care process. The first article in this series examined the patient's responsibility for his/her safety when receiving health care (SpineLine, July/August 2002, pgs. 21-22). The second part examined some of the health care provider's roles and responsibilities in the patient safety process (SpineLine, September/October 2002, pgs. 15-16). This last article will discuss the role of the institution.

Institutions, be they hospitals, long-term care facilities or ambulatory care centers, provide more than just the locale in which health care takes place. The administration of these organizations also sets the tone for staff, provides resources and oversees legal and regulatory issues. Because of involvement in these areas, the health care institution plays as large a role in patient safety as physicians and nurses.

In fact, the institution's role in patient safety is no longer just good, common-sense patient care or good business, but a regulatory mandate by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). According to JCAHO, it has developed a list of six patient safety goals for 2003 to help reduce specific medical errors. These goals relate to patient identification, effective communication, use of high-alert medications, wrong-site/patient/procedure surgery, use of infusion pumps and clinical alarm systems. Recommendations have been set for each goal. Over 17,000 accredited care organizations will be evaluated for recommendation compliance or use of acceptable substitutes beginning January 1, 2003. (The JCAHO patient safety goals and recommendations, along with FAQs, can be found on their Web site at www.jcaho.org).

NASS has put together the following list

of nonclinical suggestions that organizations can use to help meet their patient safety goals.

1. Create a Blame-Free Environment

When errors occur, it is important to determine why it happened and help change processes so it can't happen again. Don't look for individuals to blame, look for multiple systemic causes. If an institution has a nonpunitive error reporting system – encourage staff and administration to use it. If considering development of a reporting system, be an advocate for nonpunitive reporting. People who are afraid of being blamed for errors or being "outed" for reporting them, simply won't – allowing errors to go on unchecked.

2. Build Relationships with Important Staff Liaisons

It is important for patient safety policy makers to build relationships with clinical staff leadership. Liaisons with well-regarded, leading physicians and allied health professionals can go a long way toward effective two-way communication between administration and staff. Health care professionals may be willing to discuss safety issues or policy concerns with



a colleague (who may share this information with policy makers) more readily than with an administrator. And, vice versa, these people are good conduits for passing safety information and policy to the troops as well as giving credibility and buy-in to program development and implementation.

3. Staffing

Review staffing. Is it adequate? Could your institution do more to recruit qualified doctors and nurses? Too few physicians or nurses means people are spread too thin and are more prone to inadvertent errors. Shortages of qualified health professionals also contribute to medical errors when they are replaced with less costly, less qualified assistants.

4. Match Programs to Reality

In order to implement successful patient safety programs, the safety initiatives must match the reality of your institution. For example, it is probably inappropriate to create a policy with burdensome and unnecessary documentation for departments that may be understaffed and already overloaded with paperwork. Programs should be consistent with the resources (time, staffing, money, training) available. Otherwise they may be doomed to failure from the outset.

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5. Start Small

When implementing new patient safety programs, start with small trials. Beginning with small tests can help work out the “kinks” in advance and save everyone a lot of frustration. Imagine 100 frustrated people trying to comply with a new program versus five. Preventing early frustration with patient safety efforts will help build buy-in and compliance and not overload people with too much change. Sometimes smaller changes are easier to accept than big ones.

6. Share Your Victories

When institutions are asking large numbers of people to participate in patient safety efforts, it's important to share the victories as well as the defeats. Too many times organizations tell people how to do things, how to do them differently or what they're doing wrong and don't share the victories they've all achieved together (eg, reduction in wrong patient surgeries, fewer medication errors).

7. If You Can Afford It, Make Necessary Expenditures

Of course, all institutions need to remain profitable. However, if an institution can afford it, patient safety is a place where it is important not to be stingy. A few dollars on prevention can save a lot of money in containment and legal fees.

8. Remember the People...

Institutions are made up of people, not buildings. Health care professionals and administrators work together for the benefit of the patients. Don't let bureaucracy bury humanity.

Acknowledgment

Pamela M. Hayden contributed to this article. Pamela is the Senior Manager of Research at the North American Spine Society.