Leading Patient Safety

Society for Quality In Health Care in Nigeria
Stephen M. Powell, MS
CEO and President
Healthcare Team Training (HTT)
September 11, 2013

Administration

Learning Outcomes

- Describe the elements of an effective patient safety program
- List the mandates and drivers for effective leadership to promote patient safety
- Define 7 proven leadership strategies for preventing patient harm
- Integrate the 7 leadership practices with your leaders and your patient safety programs
- Identify simple methods for measuring and reporting patient safety and quality improvement
- Describe the impact a culture of safety has on sustaining gains in safety and quality
- Apply new leadership skills to current organizational challenges and opportunities for improvement

My Background

SQHN Pre-Workshop Survey

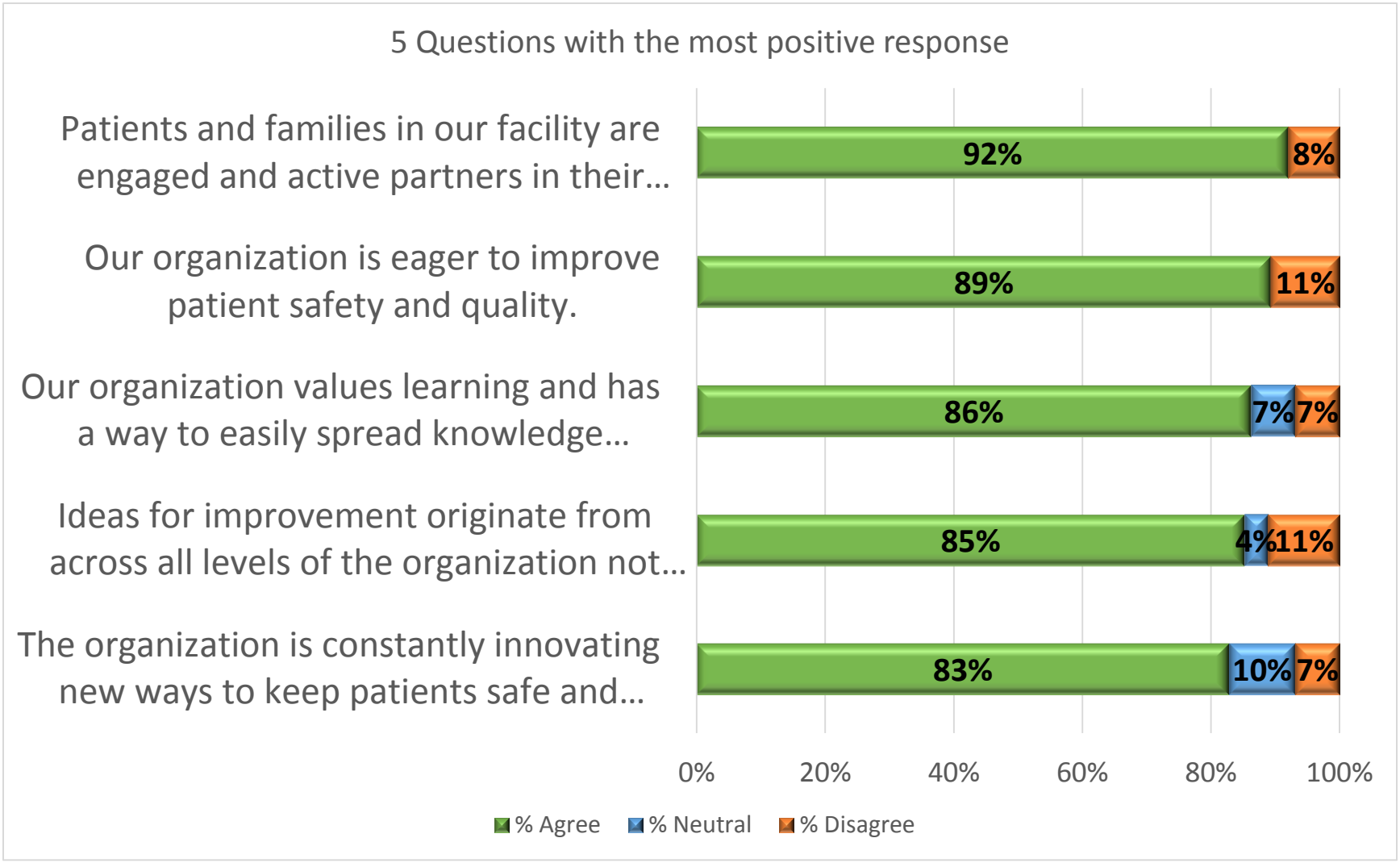
September 11, 2013

Survey

- 20 Items regarding patient safety and quality
- Sent to participants registered to attend workshop
- 29 Responses to the survey

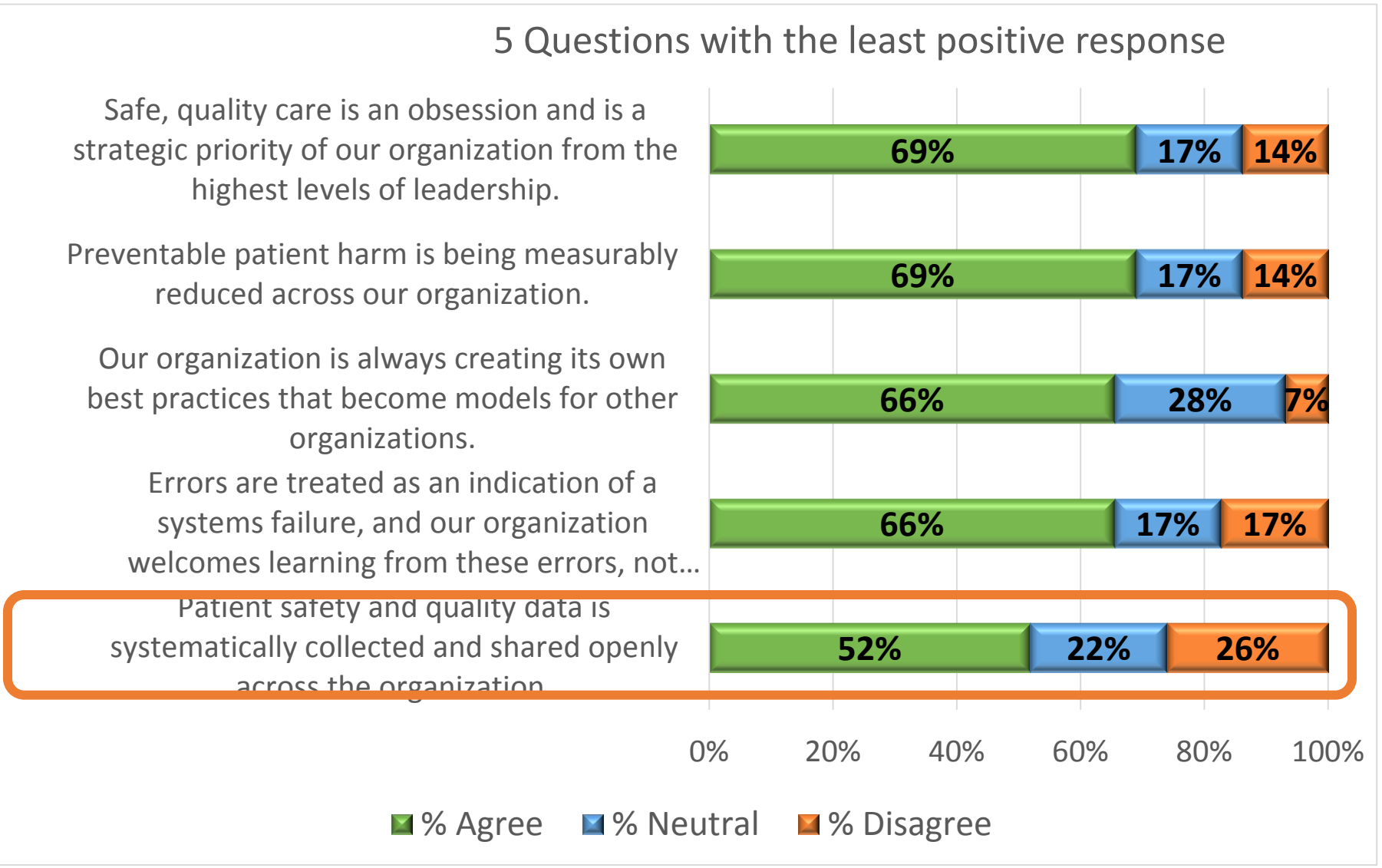
Top Questions

Top 5 Questions



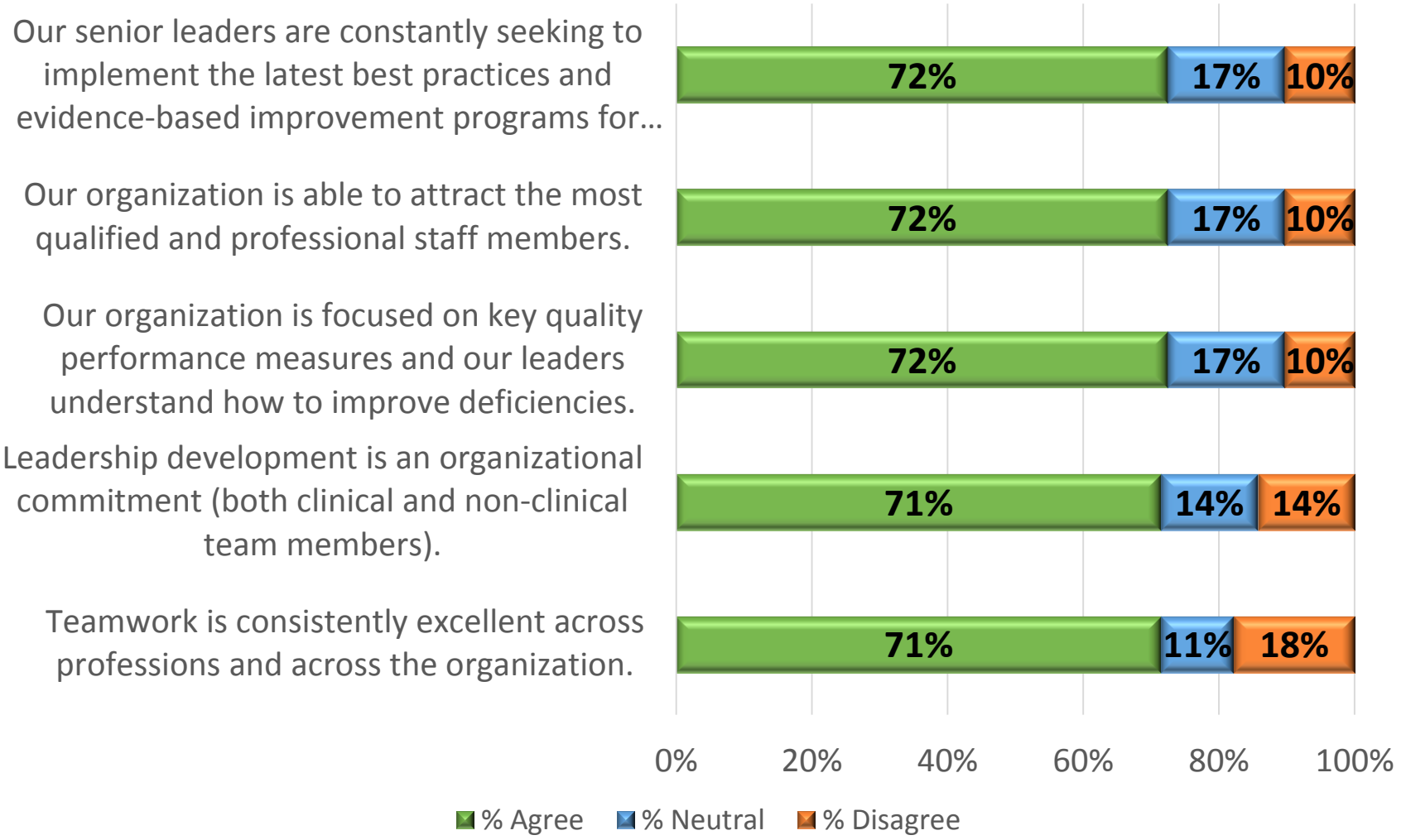
Bottom Questions

Bottom 5 Questions

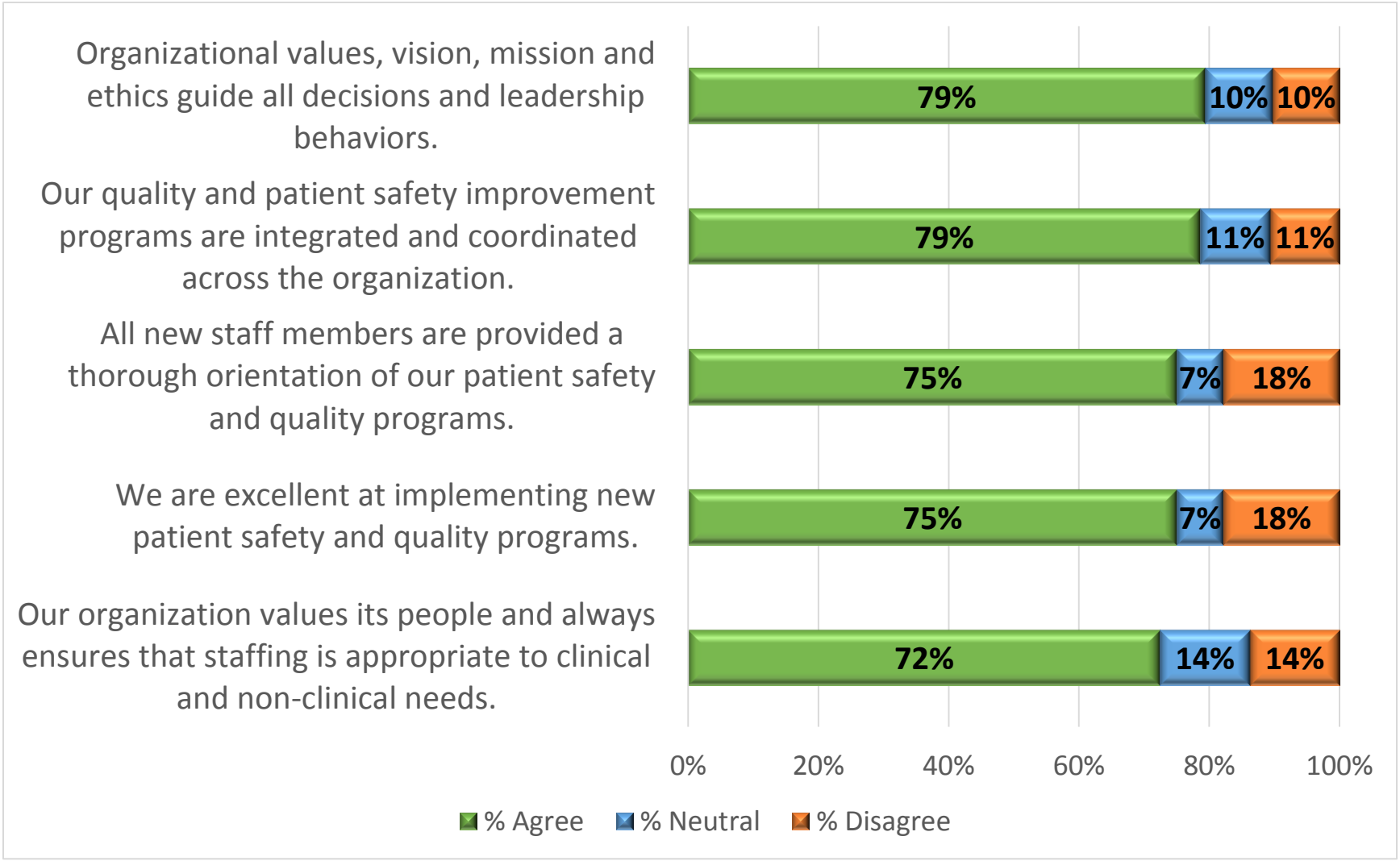


Other Questions

Other Responses



Other Responses



Conclusions

- Strong positive perceptions of state of patient safety and quality
  - Would our front line staff agree?
- Strong perceptions of organizational eagerness to improve patient safety and mechanisms to do so
  - How are organizations generating ideas from all levels and spreading learning?
- Opportunity to better measure and track patient safety
  - Where is this being done well?
- Opportunity to respond to error in a just way
  - How are errors currently handled?

Definition of Patient Safety

- The prevention and mitigation of harm caused by errors of omission or commission that are associated with healthcare, and involving the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur.

Angood, P., Colchamiro, E., Lyzenga, A., and Marinelarena, M. *Meeting of the National Quality Forum Patient Safety Team*. Washington, DC. August 2009.

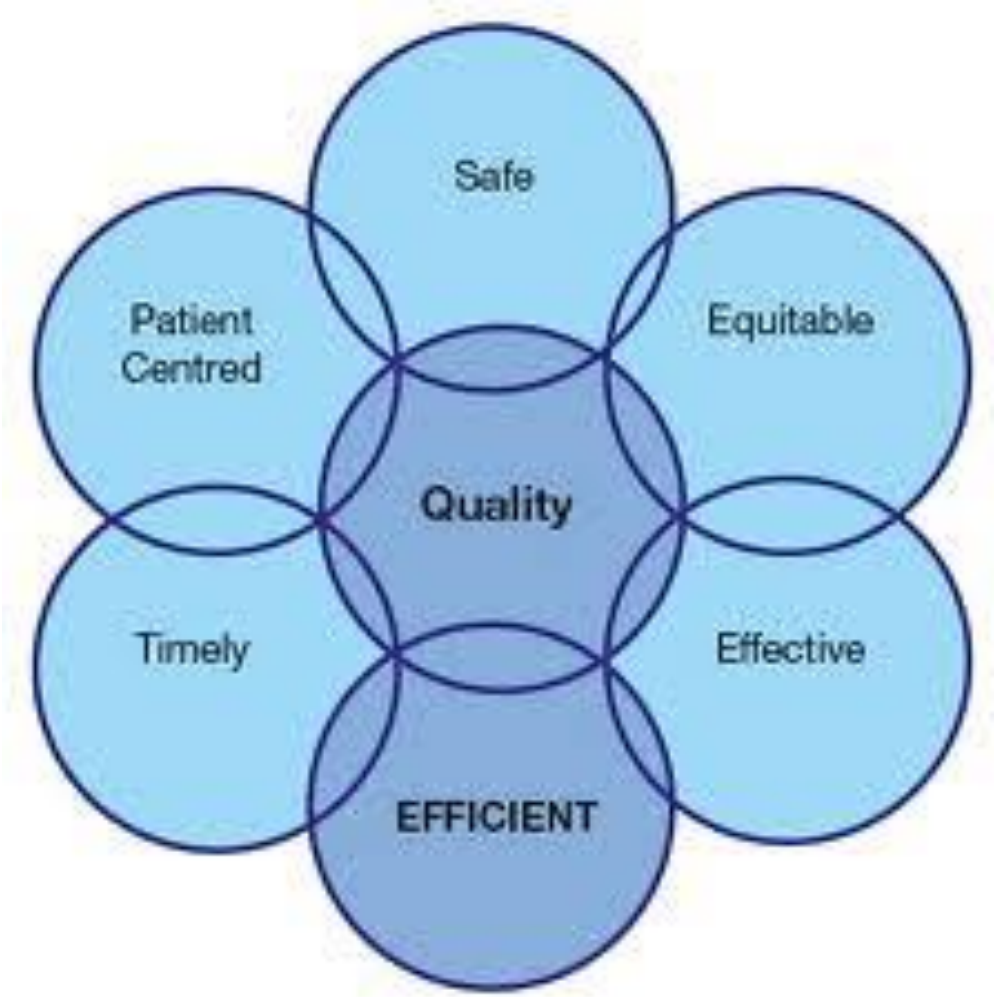
International Patient Safety Goals

Goals

Goal 1 Identify Patients Correctly
Goal 2 Improve Effective Communication
Goal 3 Improve the Safety of High-Alert Medications
Goal 4 Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery
Goal 5 Reduce the Risk of Health Care–Associated Infections
Goal 6 Reduce the Risk of Patient Harm Resulting from Falls

Source : Joint Commission International

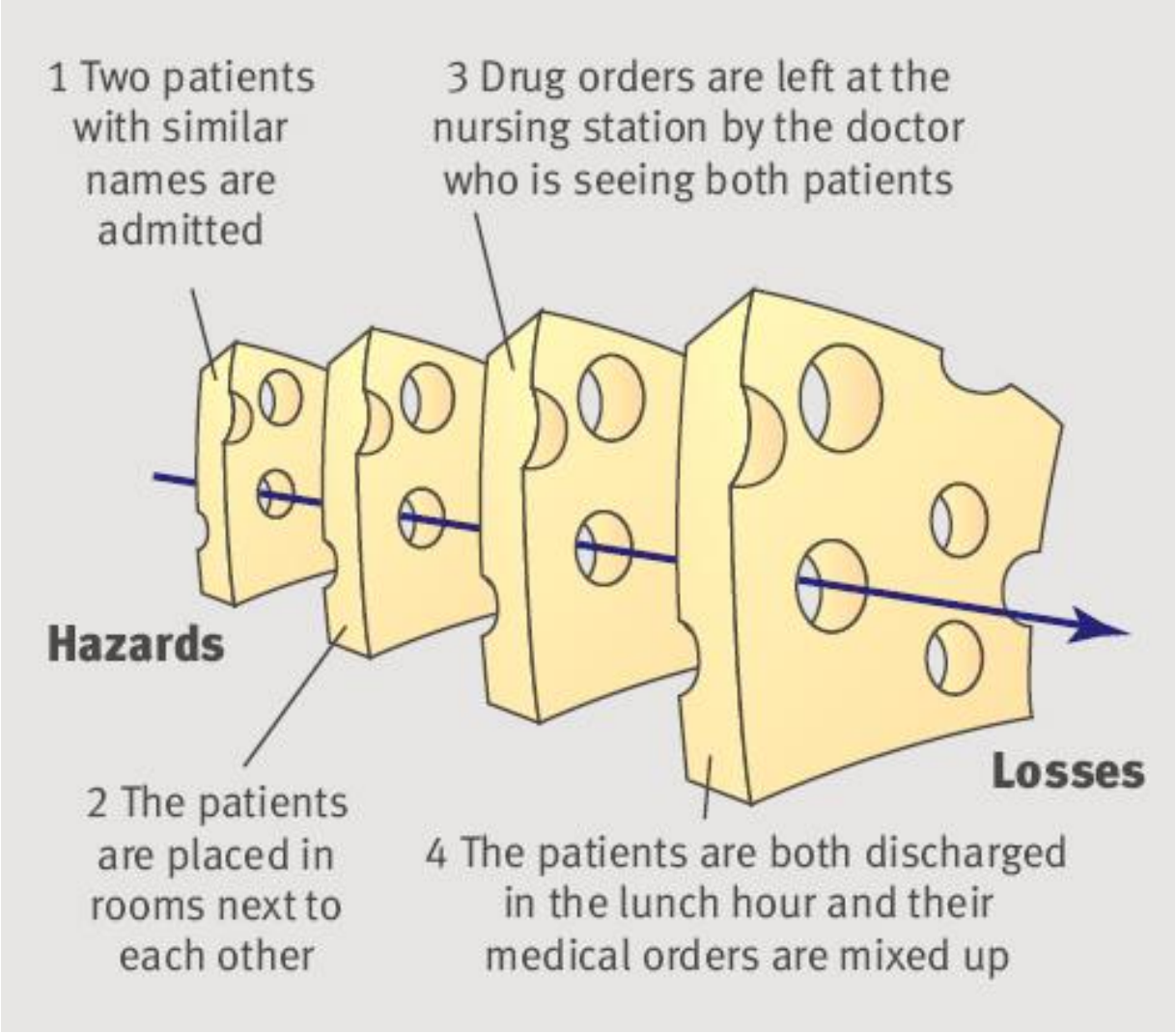
Definition of Quality in Health Care



Source: Institute of Medicine

Elements of an Effective Patient Safety Program

Human Error is Inevitable



Reducing Preventable Patient Harm

Themes, Insights and Key Points

How safe is your Health Care system?

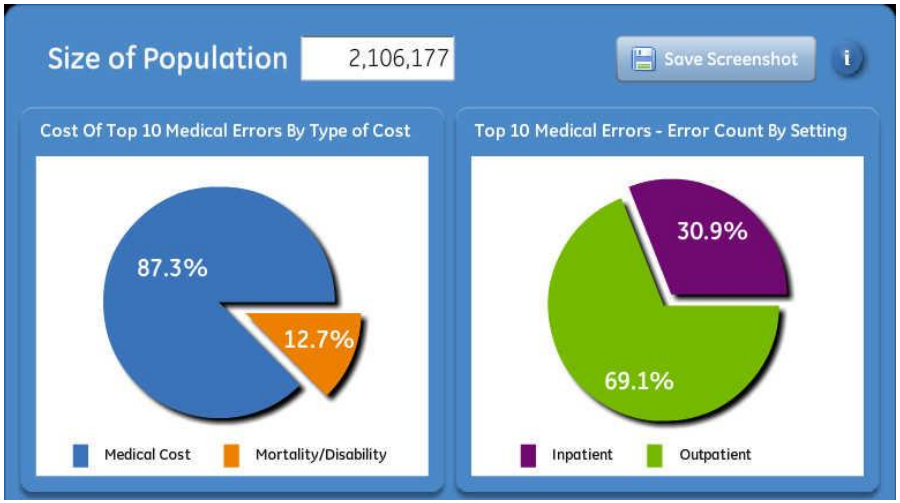
- 1 in 7 patients suffer a medication error
- **35%** of *physicians* family members
- **42%** of the *public's* family members
- **Every 2.5 min, 1 American dies of sepsis**

98,000 people die each year due to medical error!

270 each day in the U.S.

Source: Institute for Medicine

Cost of Preventable Harm

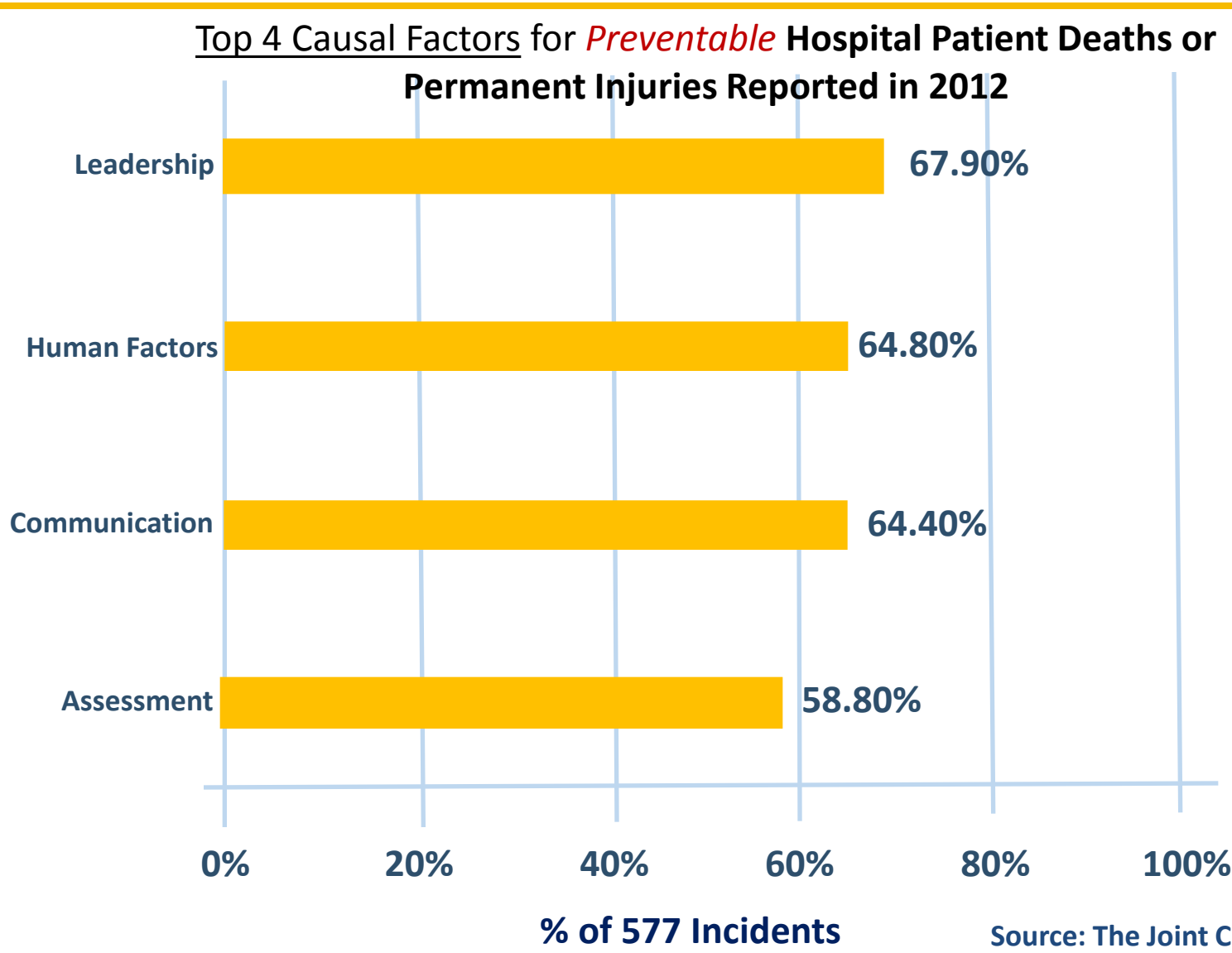


Preventable Harm

$84,604,229

$25,464,543

Top Reasons for Preventable Harm

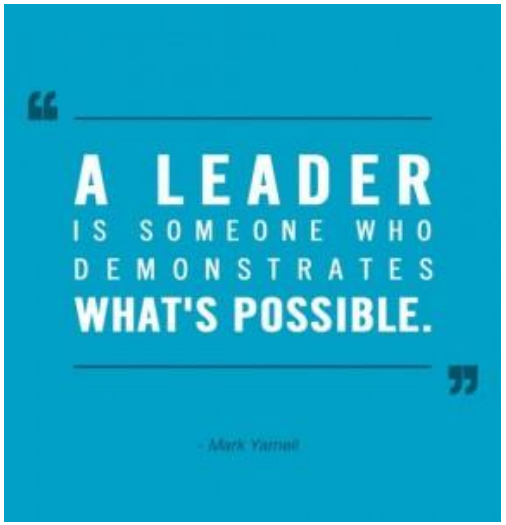


Source: The Joint Commission

Our Approach

A ***people-centric approach*** to patient safety & quality

Leadership versus Management



Traits of Effective Leaders

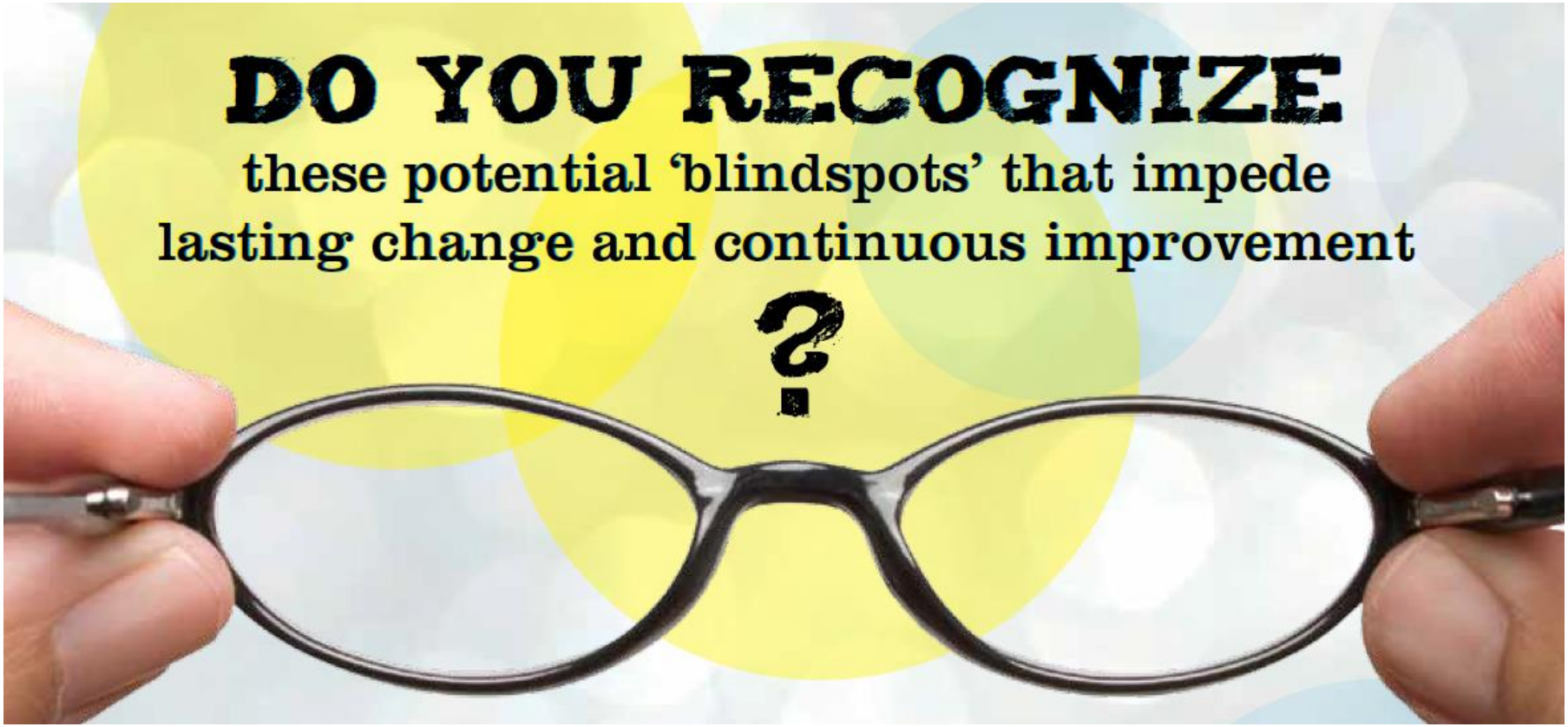
Group Exercise

Envision your work 10 years from today. All has gone relatively well, and you achieved most of what you set out to do in your role. List 20 single words that best summarize how you would describe the patient safety and quality efforts in your organization at that time.

1. Circle the 10 words that best capture your vision.
2. As a group, share your 10 words with each person at the table, adding to your list if you like the words of others.
3. Select 4 words that best capture your vision of the future, write them down again, and share with your group.
4. Select the 1 word that best captures your vision of the future, write it down again, and share with your group.
5. Hand in your 4 words, and your ultimate 1 word.

Creating a New Vision

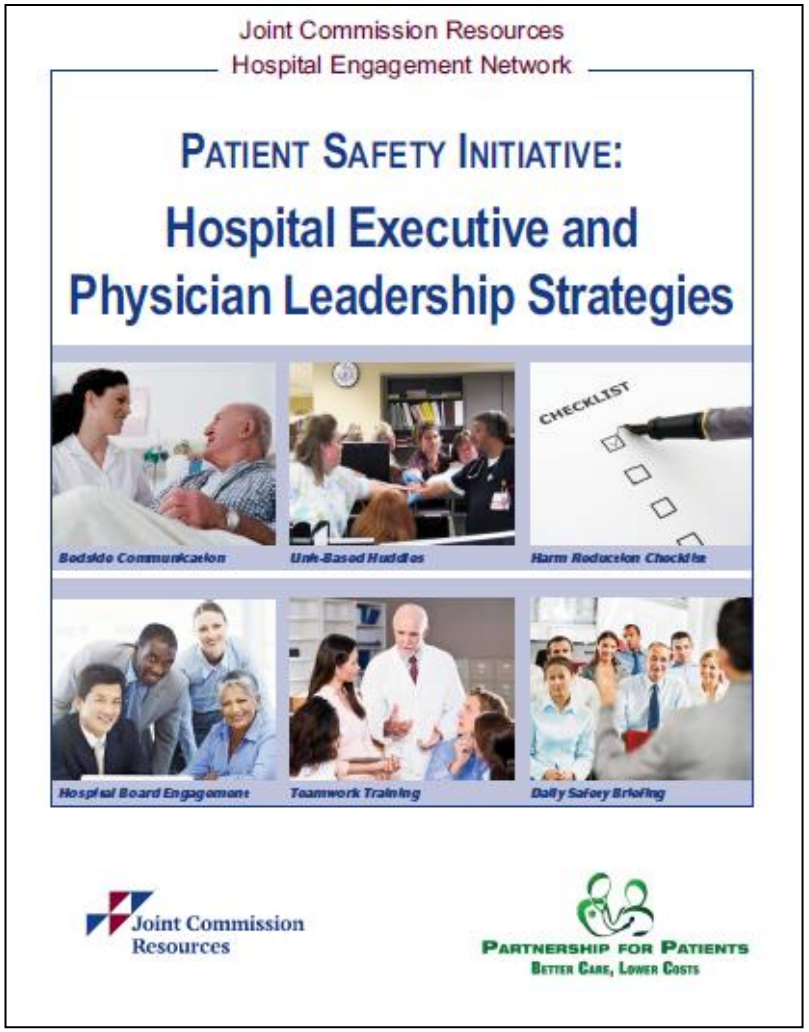
Common leadership ‘blindspots’ or biases



Identifying your ‘Blindspots’ Exercise

1. Review the handout.
2. Identify your personal ‘blindspots’.
3. Share with the person next to you how this has become a ‘blindspot’ and how you can improve.
4. Switch roles and repeat.

New Toolkit for Leaders



Reducing Harm: Hospital-Acquired Conditions

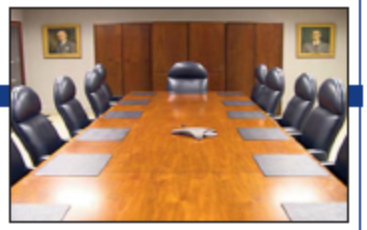
Over 30% Reduction in 18 months!

- Ventilator-Associated Pneumonia
- Central Line Infections
- Pressure Ulcers
- Adverse Drug Events
- Surgical Site Infections
- Early Elective Newborn Deliveries

Board Engagement in Patient Safety

PATIENT SAFETY INITIATIVE:
Hospital Executive and
Physician Leadership Strategies

Board Engagement in Patient Safety



One of the most important interventions for hospital leadership in developing a hospital safety program is to get the hospital's Board involved with safety and quality.[1]

What Is the Practice?

Establish a standing Board-level committee on patient safety and quality improvement, with goals, metrics, and regular reviews with hospital executives.

Why Use the Practice?

- Board's commitment to safety reinforces its value as an essential ingredient of the organization's culture.
- Board can reinforce safety behavior at all levels.
- Aligns the Board and the leadership team around the strategic goals for patient safety.

Instructions for Conducting the Practice

Increase the Board's Quality Literacy

- ✔ Educate the Board on salient quality issues.
- ✔ Consider adding quality experts to the Board.
- ✔ Use retreats for having in-depth dialogue on quality and safety improvement projects.
- ✔ Have Board members attend quality conferences.
- ✔ Consider adding a Board member who comes from a high reliability organization who has executive responsibility for quality in their organization.

Frame an Agenda for Quality

- ✔ Initiate discussion between the Board chair and Chief Executive Officer (C.E.O.) on the status of quality.
- ✔ Ensure that quality and safety on the Board agenda gets equal billing with other agenda items.

Engage in Quality Planning and Focus and Provide Incentives

- ✔ Create a vision for quality for the hospital with long-term outcome measures and goals.
- ✔ Review the hospital's quality plan and ensure it is aligned with the overall strategic plan.
- ✔ Ensure the quality measures the Board reviews are assessed regularly and are presented in a manner that the non-clinical trustee can understand.
- ✔ Integrate the quality measures into the overall Board performance.
- ✔ Link incentive compensation of leadership to quality metrics.

Patient-Centeredness

- ✔ Share patient stories at Board meetings to further increase focus on patient-centeredness.
- ✔ Ensure that patients are involved in improvement by having patients participate on improvement committees and projects.
- ✔ Ensure the appointment of at least one patient member to the Board.

Reference

1. Whittington J. Key Issues in Developing a Successful Hospital Program. *AHRQ Morbidity and Mortality Rounds on the Web*. Agency for Healthcare Research and Quality. Jul 2006. Accessed May 20, 2015. http://webmm.ahrq.gov/perspective.aspx?perspectiveID=27

For More Information

1. Joshi MS, Hines SC. Getting the board on board: Engaging hospital boards in quality and patient safety. *Jt Comm J Qual Patient Saf*. 2006 Apr;32(4):179-87.
2. Agency for Healthcare Research and Quality. Safe Practices for Better Healthcare: A Consensus Report. Safe Practice 1, pp 6-9. Accessed May 10, 2015. http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/safepract.html.

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Safety Culture Debriefing

PATIENT SAFETY INITIATIVE:
Hospital Executive and
Physician Leadership Strategies

Safety Culture Debriefing

The CEO and senior administrative leaders should be directly involved in the application of the knowledge that has been generated through the measurement of culture.[1]

What Is the Practice?

At least annually, leaders should assess the organization's safety and quality culture using a survey tool that is selected with consideration of validity, consistency, and reliability in the setting in which it will be applied and that is conceptualized around domains that are applicable to performance improvement initiatives/efforts such as teamwork, leadership, communication, and openness to reporting. The results of the culture survey process should be documented and disseminated widely across the enterprise in a systematic and frequent manner. The interventions component of this safe practice will be satisfied if the survey findings are documented and have been used to monitor and guide performance improvement interventions.

Why Use the Practice?

Studies show positive correlations between a high culture of safety score with (1) improved clinical outcomes such as lower hospital-acquired infection rates and (2) higher staff retention because of higher morale, lower burnout, and less absenteeism.

Instructions for Conducting the Practice

Measurement of the culture of safety by itself is not enough. The results must be fed back to the organization to stimulate discussions about areas of weakness and solutions for improvement. Because culture resides at the local level, it's important to discuss the results by departments, units, and roles. Focusing on group-level data depersonalizes the discussion and fosters actionable ideas for improvement in the context of the local realities of care delivery. More than simply a measuring stick, feedback to respondents at the work-unit level can actually be the first step in improving culture. Leadership needs to provide a structure for reviewing the results with frontline caregivers and managers to identify specific areas of concern and obtain insights and recommendations on how to address the issues.

Teach front line leaders how to use the data from the survey including) seeking staff interpretation of findings, 2) seeking staff solutions to identified issues and problems and 3) facilitating the creation of staff-built unit level workplans based on their ideas for improvement to improve the safety culture.

Reference

1. National Quality Forum. Safe Practices for Better Healthcare. 2006 Update. A Consensus Report Accessed May 16, 2013. http://www.bu.edu/fammed/projectcrnf/NQFSafePractices.pdf

For More Information

1. Joshi MS, Hines SC. Getting the board on board: Engaging hospital boards in quality and patient safety. *Jt Comm J Qual Patient Saf.* 2006 Apr;32(4):179-87.
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3. Vogelzio MC., et al. Improving safety culture results in Rhode Island ICUs: Lessons learned from the development of action-oriented plans. *Jt Comm J Qual Patient Saf.* 2011;37(11):509–514.

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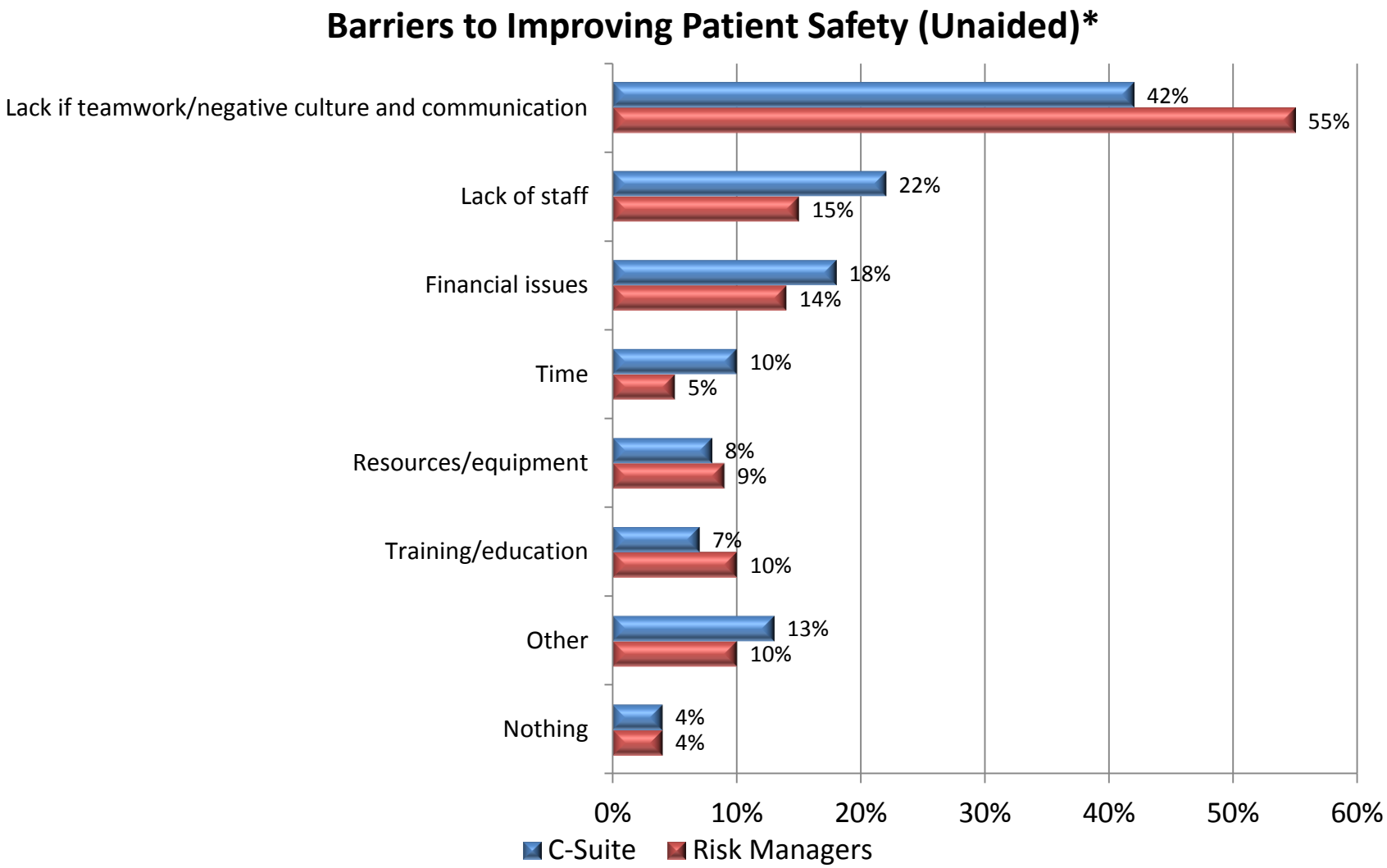
Top Barriers to Improving Patient Safety



Source: AIG 2013

Key Beliefs in a Safety Culture

- Four key beliefs in a positive Safety Culture

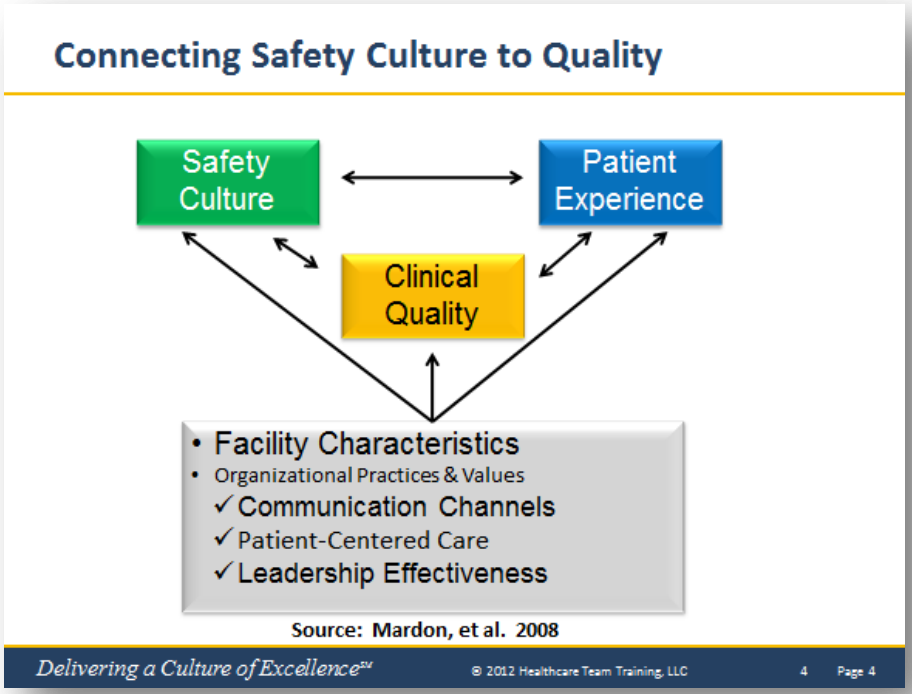
1. Our processes are designed to prevent failure.
2. We are committed to detect and learn from error.
3. We have a just culture that disciplines based on risk.
4. People who work in teams make fewer errors.

Source: Institute of Medicine (2004)

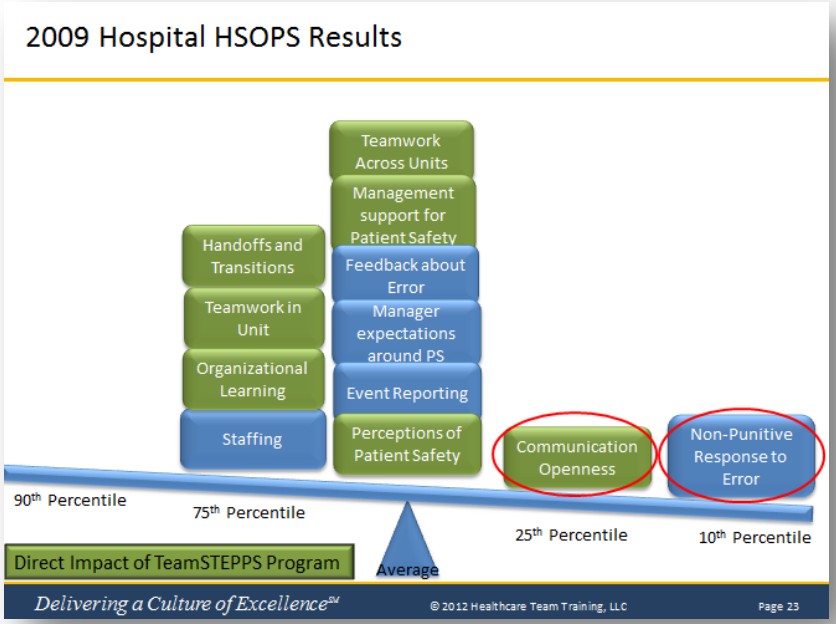
Overview of Safety Culture

What makes up a Safety Culture?

Connecting the dots between Safety Culture, Patient Experience, and Clinical Quality!

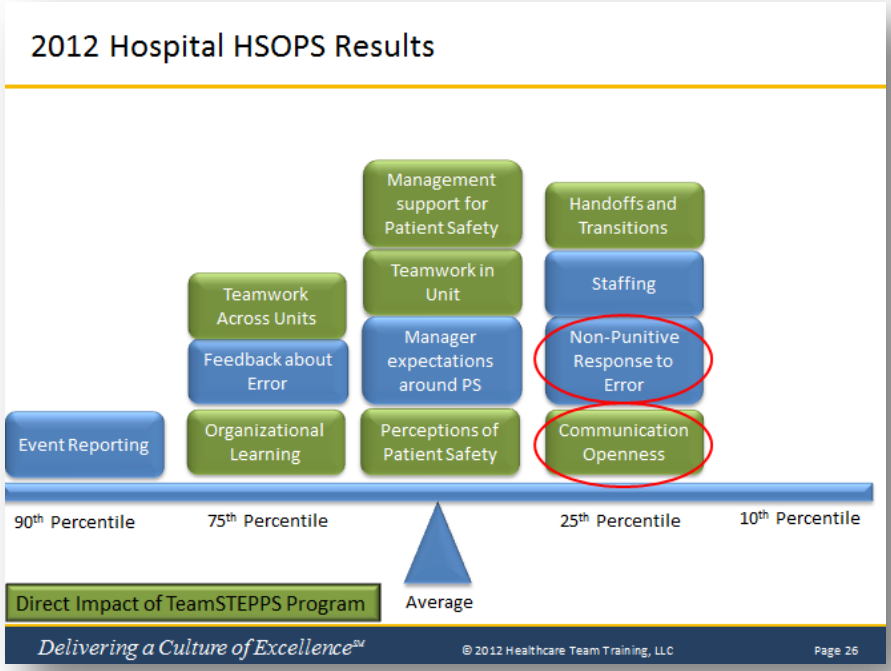


How the data is presented

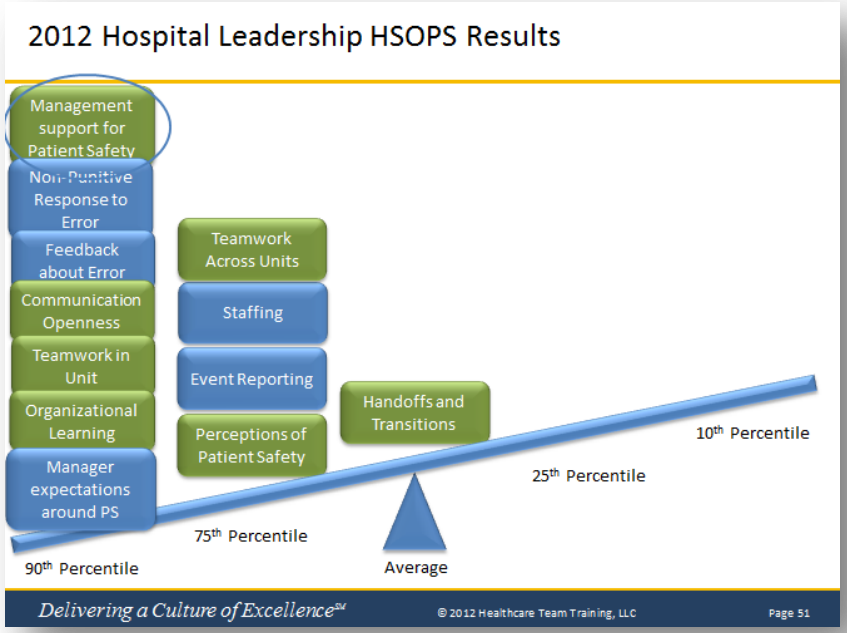


Safety Culture "See-Saw"

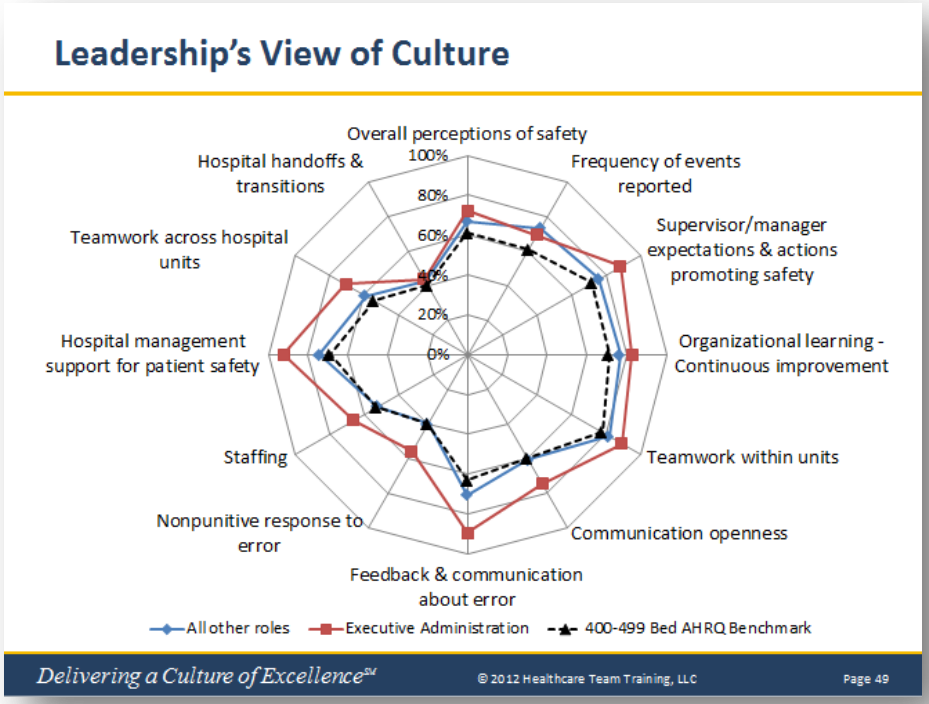
Tracking your hospital's progress over time and analyzing trends in the data



Leadership Slides

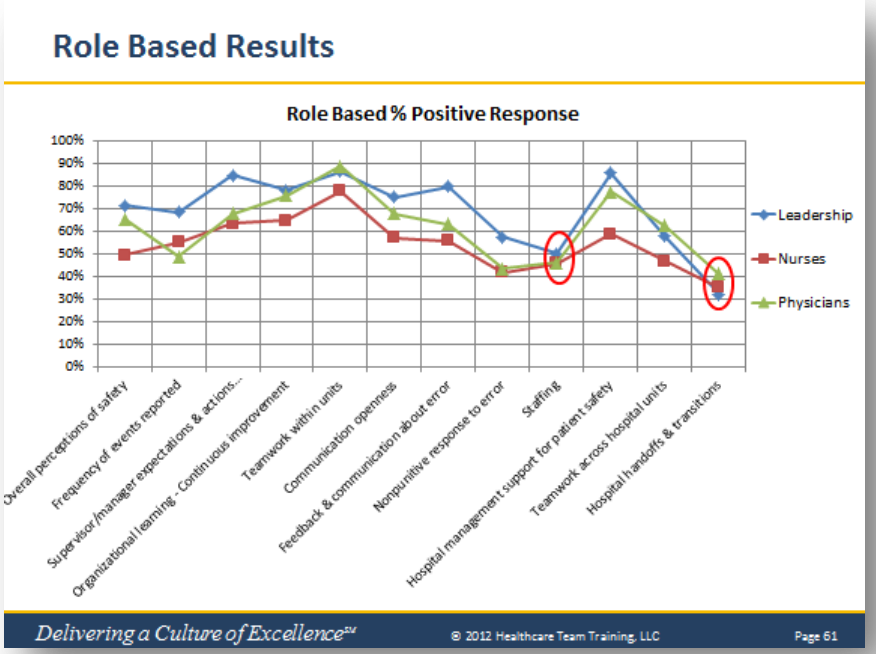


Leadership's view of safety culture as compared to the Hospital's view



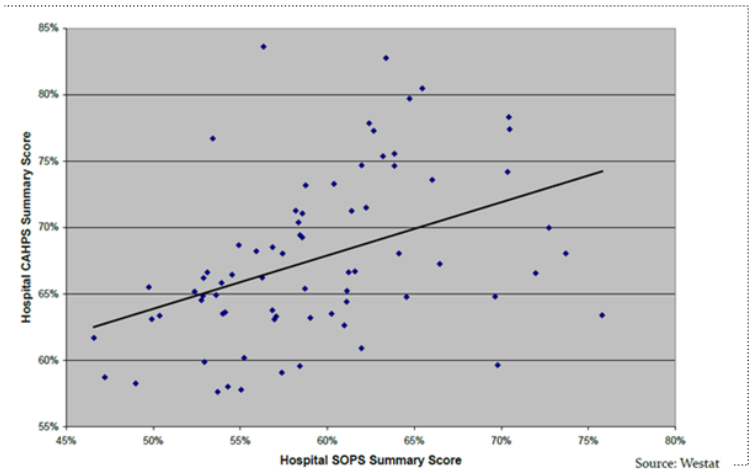
Text and Role Based Analysis

We will take a look at the difference in perception of Nurses, Physicians, and Leadership and identify gaps or disconnect

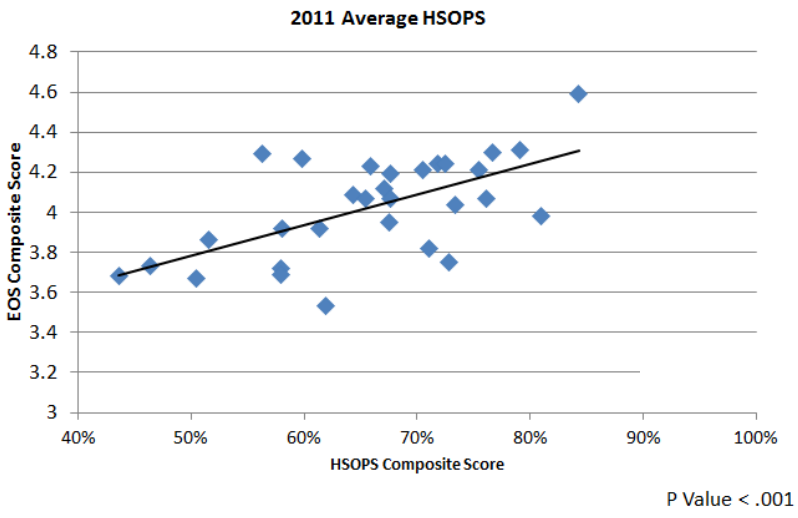


Correlation Analysis

HSOPS - HCAHPS



Employee Engagement



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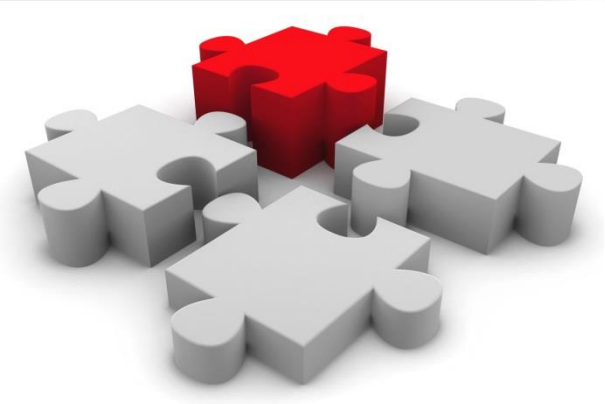

Safety Leadership Rounds

PATIENT SAFETY INITIATIVE:
Hospital Executive and
Physician Leadership Strategies

Safety Leadership Rounds

(also known as WalkRounds)

Organizations across the world are . . . using the WalkRounds program as a mechanism to engage senior leaders in efforts to improve the reliability of care in their organizations.[1–3]

What Is the Practice?

Safety Leadership Rounds are conducted in patient care departments such as the emergency department, medical surgical floors, and the operating room, as well as in ancillary departments such as the imaging and laboratory areas. Senior leaders go to the department weekly and conduct informal conversations with staff members about safety issues. Safety Leadership Rounds provide a method for leaders to talk with frontline staff about safety issues in the organization and show their support for safety practices.

Why Use the Practice?

- Demonstrates commitment to safety
- Fuels culture for change pertaining to patient safety
- Provides opportunities for senior executives to learn about patient safety
- Identifies opportunities for improving safety
- Establishes trusting relationships and lines of communication about patient safety among employees, executives, and managers

Instructions for Conducting the Practice

Ground Rules

- ✔ Organizations should decide whether or not to announce the time and place of Safety Leadership Rounds, and the decision should be agreed to by senior leaders and managers.
- ✔ Organizations should reassure employees that all information discussed in Safety Leadership Rounds is strictly confidential.

Who Should Conduct Safety Leadership Rounds?

- ✔ All "C-suite" leaders, usually including the C.E.O., chief operating officer (C.O.O.), chief medical officer (C.M.O.), and chief nursing officer (C.N.O.).
- ✔ Senior leaders should commit to conducting Safety Leadership Rounds at a minimum of once per week, for a minimum of one year, with no cancellations.
- ✔ Members of the senior executive team can rotate for easier scheduling, but every senior leader should perform a Safety Leadership Round every week.

Sample Questions

- ✔ "Have there been any near misses that almost caused patient harm but didn't?"
- ✔ "Is there anything we could do to prevent the next adverse event?"
- ✔ "What specific intervention from leadership would make the work you do safer for patients?"
- ✔ "How are you engaging patients and families in their care?"

Reference

1. Frankel A, Pratt S. Systematic flow of information: The evolution of Walkrounds. In Leonard M, et al., editors. *The Essential Guide for Patient Safety Officers*, Second Edition. Oak Brook, IL: Joint Commission Resources, 2013;45–52.

For More Information

1. Frankel A, et al. Patient Safety Leadership WalkRounds.™ *Jt Comm J Qual Saf.* 2003;29(1):16–26. Accessed May 10, 2013. http://patientsafety.uasc.edu/documents/LeadershipWalkRounds.pdf.
2. Frankel A, et al. Patient Safety Leadership WalkRounds at Partners Healthcare: Learning from implementation. *Jt Comm J Qual Patient Saf.* 2005;31(8):423–437.
3. Health Research and Educational Trust. Patient Safety Leadership WalkRounds.™ Accessed May 10, 2013. http://www.hret.org/quality/projects/patient-safety-leadership-walkrounds.shtml.

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Getting to the Heart of the Matter

Teamwork and Communication

PATIENT SAFETY INITIATIVE:
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Teamwork Training and Skill Building

The CEO and senior administrative leaders should be directly involved in ensuring that the organization implements the activities detailed in the specifications of the Teamwork Training and Skill Building safe practice. This includes participating in the defined basic training program.[1]

What Is the Practice?

Provide both basic and detailed teamwork training.

Basic Teamwork Training. Basic teamwork training should be provided annually to governance Board members, senior administrative leaders, medical staff (whether independent or employed by the organization), midlevel management, and frontline staff. The subject matter should include sources of communication failures, handoffs, and team failures that lead to patient harm. The length and modality of training should be established by the organization. Participation should be documented to verify compliance.

Detailed Teamwork Training. All clinical staff and licensed independent practitioners should receive detailed training consisting of the best available teamwork knowledge; however, staff of clinical areas, such as labor and delivery and critical care units, that are deemed to be at high risk for patient safety issues, should receive such training first. The clinical areas that are prioritized should focus on specific patient safety risks. The subject matter should include the principles of high reliability, human factors applied to real-world care processes, interpersonal team dynamics, handoffs, and specific communication methods. Focus should be placed on the development and application of structured tools.

Why Use the Practice?

- Care has become fragmented, necessitating successful team communication to prevent system failures.
- Organizations are treating sicker patients at ever faster rates with treatments that are becoming increasingly complex.

Failure of teamwork and communication has been consistently cited as a primary root cause of sentinel events reported to The Joint Commission.[2] In a systematic review of emergency department closed claims, fundamental teamwork behaviors would have prevented or mitigated the adverse event in 43% of reviewed cases.[3]

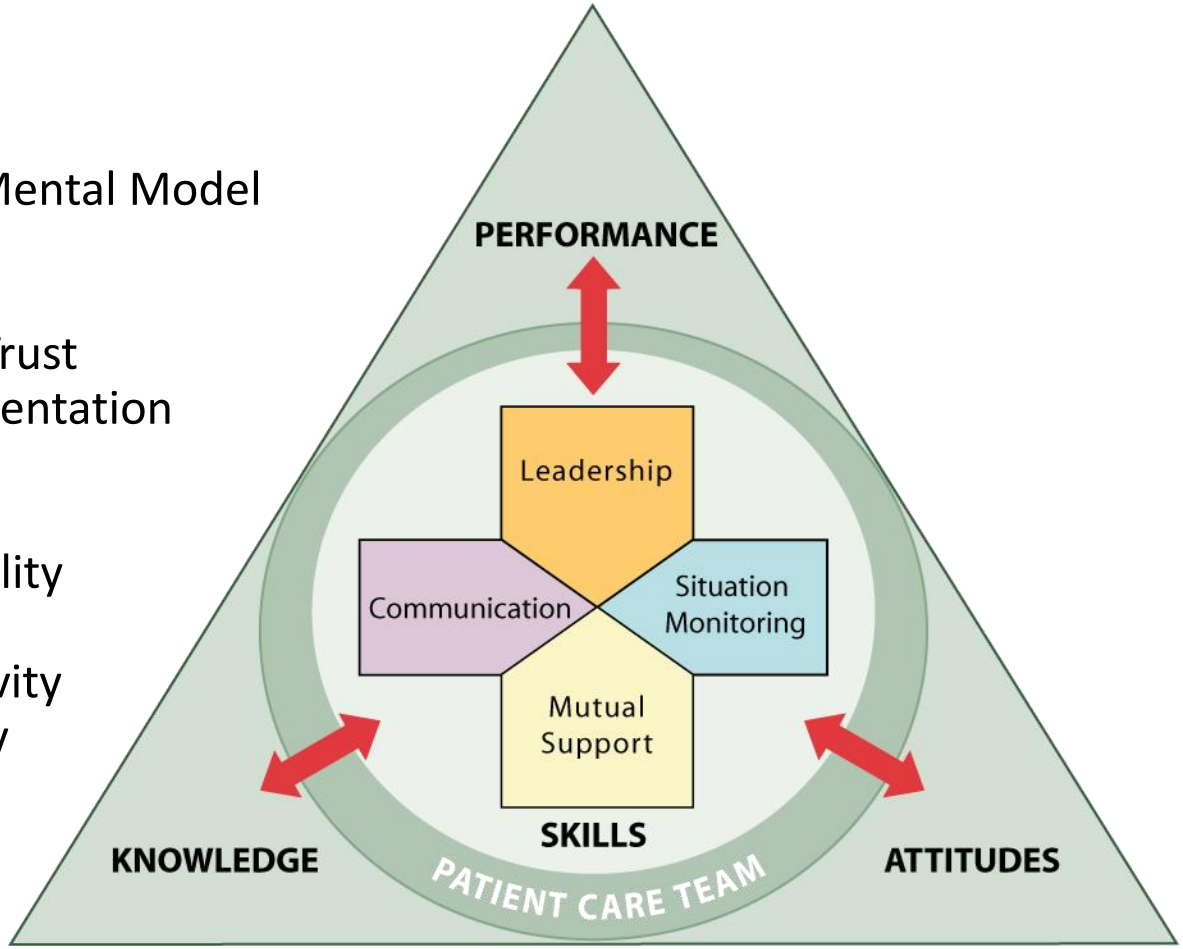
Instructions for Conducting the Practice

Most health care organizations either contract with an external firm to provide the initial teamwork training or send employees of the organization to be trained as trainers. After those employees are trained, they then in turn conduct the relevant trainings. Sometimes, a combination of both approaches is used. The TeamSTEPPS® program, developed jointly by the US Department of Defense Patient Safety Program and the Agency for Healthcare Research and Quality (A.H.R.Q.), is freely available for download from the AHRQ website, and AHRQ has provided funding for the national implementation of TeamSTEPPS®.[4] Commercial programs are readily available.

(continued on page 11)

Outcomes of TeamSTEPPS®

- **Knowledge**
  - Shared Mental Model
- **Attitudes**
  - Mutual Trust
  - Team Orientation
- **Performance**
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety



Promoting Strong Clinical Team Leadership

Daily Safety Briefing

PATIENT SAFETY INITIATIVE:
Hospital Executive and
Physician Leadership Strategies

Daily Safety Briefing

Attention is the currency of leadership.[1]
—Lee Carter, Chairman of the Board,
Cincinnati Children's Hospital Medical Center

What Is the Practice?

The Daily Safety Briefing is a 15-minute meeting of the senior leaders with all department leaders of the organization, and a three-point agenda is used:

1. **Look back:** Significant safety or quality issues from the last 24 hours
2. **Look ahead:** Anticipated safety or quality issues in next 24 hours
3. **Follow-up:** Status reports on issues identified today or days before

Why Use the Practice?

- Shared situational awareness
- Heightened risk awareness
- Early identification and resolution of problems
- Demonstrated staff follow up on issues, assuming that their resolution is well communicated

Instructions for Conducting the Practice

A senior leader facilitates the meeting, typically via conference call. All other senior leaders and all operational leaders participate. The meeting occurs in the morning with an "everyone checks-in" expectation. When safety-critical issues are identified, all organizations have a mechanism for tracking issues and their resolution.

The following are examples of questions that the leader can ask during the Daily Safety Briefing to promote a risk-averse mindset and risk-averse actions in others:

- ✔ How do you know you had no problems in the past 24 hours?
- ✔ What immediate, remedial actions did you take?
- ✔ Is this happening in other places? Could this happen in other places?
- ✔ What other areas does this issue impact?
- ✔ How are you preparing your team for that high-risk task?
- ✔ What error prevention behaviors should be used?
- ✔ How was the patient/family involved in the event, or how could their involvement prevent another such occurrence?
- ✔ How will we communicate our decisions that we have made today?

Reference

1. Healthcare Performance Improvement, LLC. Best Practices in Implementing Leadership Methods. Pre-Summit Workshop. Sep 20, 2011. Grand Rapids, MI. Safety Summit 2011: Navigating Toward Zero Events of Harm. Accessed May 16, 2013. http://hpiresults.com/safetysummit/docs/2011_breakouts/Best%20Practices%20in%20Implementing%20Leadership%20Methods.pdf.

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Adopt-a-Work-Unit

PATIENT SAFETY INITIATIVE:
Hospital Executive and
Physician Leadership Strategies

Senior Executive Adopt-a-Work Unit

(Also known as Comprehensive Unit-Based Safety Program [C.U.S.P.])

The keys to program success are the active role of an executive advocate and staff's willingness to openly discuss safety issues on the units.[1-3]

What Is the Practice?

Adopt-a-Work Unit is a five-step program that pairs a hospital executive with a care unit to change the unit's workplace culture—and in so doing brings about significant safety improvements—by empowering staff to assume responsibility for safety in their environment. This is achieved through education, awareness, access to organizational resources and a toolkit of interventions. Adopt-a-Work Unit works because it recognizes the central importance of culture in sustainable patient safety improvements. Because culture is local, it must be targeted at the unit level, with support at the organizational level.

Why Use the Practice?

- Educates and improves awareness about patient safety and quality of care.
- Empowers staff to take charge and improve safety in their workplace.
- Creates high-trust partnerships between units and executives to improve organizational culture.
- Provides resources for unit improvement efforts.
- Provides tools to investigate and learn from defects.

Instructions for Conducting the Practice

✔ **Train staff in the science of safety.** Provide this training to all members of a unit—anyone who spends more than 60% of his or her time working on the unit.

✔ **Engage staff to identify defects.** Ask each staff member to answer a simple, two-question survey: How is the next patient going to be harmed on this unit? How can we prevent this harm from occurring? Also find potential areas of improvement based on review of incident reports, claims, and sentinel events.

✔ **Senior executive partnership/safety rounds.** Perform monthly safety rounds in which the executive interacts with staff on the unit and discusses safety issues with them. All staff should be invited to attend.

✔ **Continue to learn from defects.** Use the Learning from Defects tool to address the top risks identified by the team.

✔ **Implement tools for improvement.** The safety team members highlight several priority areas needing improvement and use the many tools in the public domain to address them.

Reference

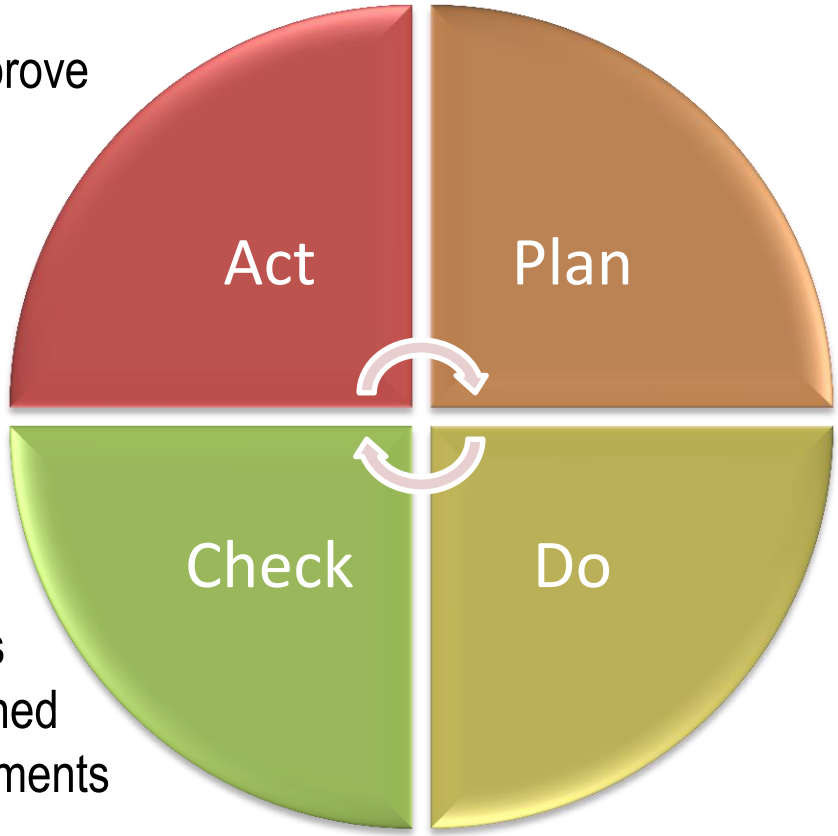
1. Pronovost PJ. Senior executive adopt-a-work unit: A model for safety improvement. *Jt Comm J Qual Saf.* 2004;30(2):59–68.

For More Information

1. Pronovost P, et al. Implementing and validating a comprehensive unit-based safety program. *J Patient Saf.* 2005;1(1):33–40.

The PDCA Cycle of Improvement

Take Next Steps to Improve
- Adopt
- Adjust
- Abandon



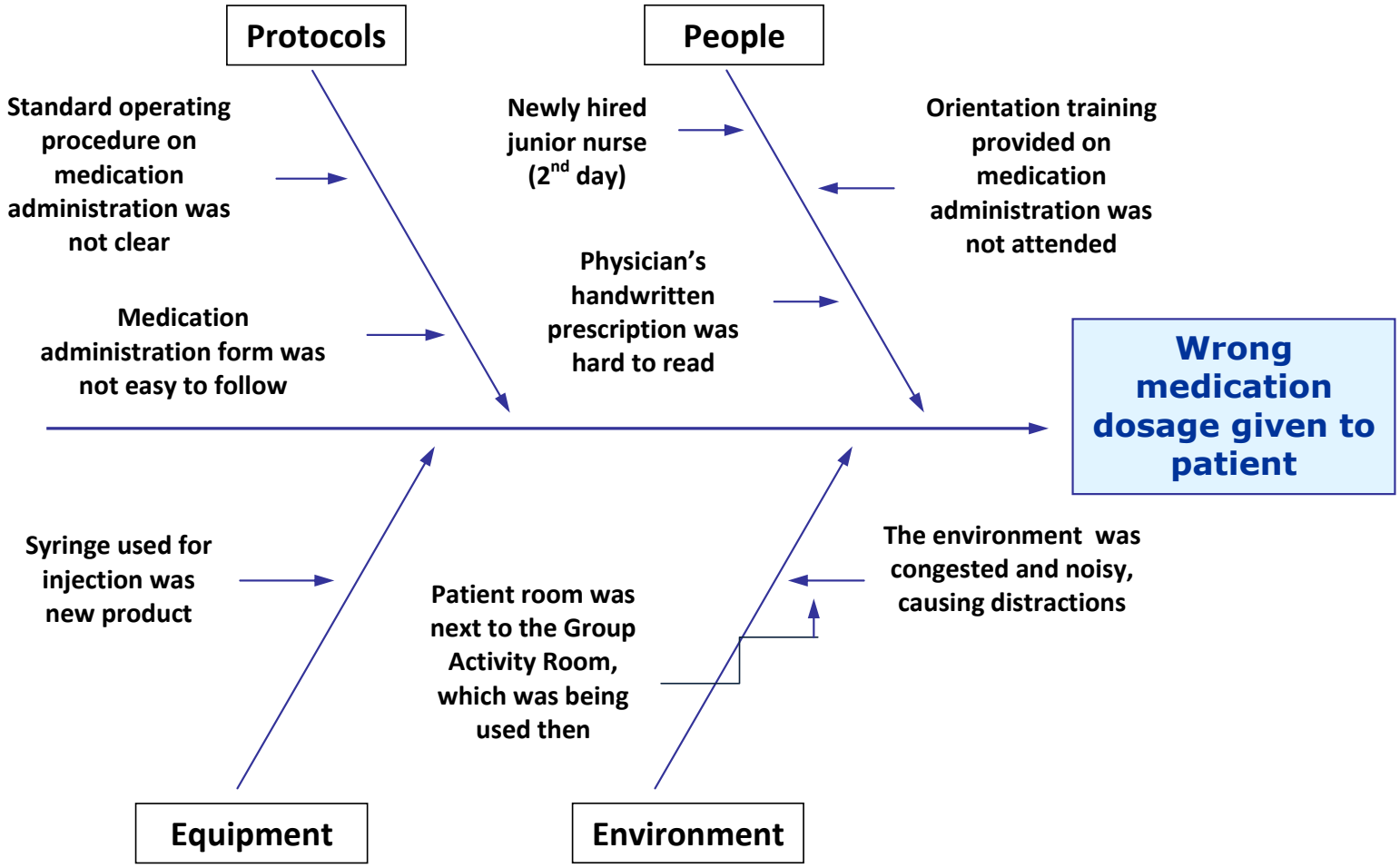
Design/Redesign Process
- What, Who, How
- When, Where

Evaluate Results
- Analyze data results
- Obtain lessons learned
- Brainstorm improvements

Implement Process
- Pilot process, if possible
- Collect data

Source: Institute of Medicine (IOM)

Cause-and-Effect Diagram



Best Practices of Execution

PATIENT SAFETY INITIATIVE:
Hospital Executive and
Physician Leadership Strategies

Best Practices of Execution

The first discipline of execution is to focus your finest effort on one or two goals instead of giving mediocre effort to dozens of goals.[1]

What Is the Practice?

Use a disciplined, structured approach for implementing and executing patient safety strategies, including

- Focus
- Leverage
- Engagement
- Accountability

Why Use the Practice?**

- 75%–80% of all initiatives that require people to change behavior fail.
- Implementing complex changes requires extraordinary discipline.
- Enables focused improvement efforts at the unit level to maintain the highest priority and not get lost in the "whirlwind" of the daily work flow.
- Enables leaders to assess organizational resources and capabilities to advance performance improvement

Instructions for Conducting the Practice

✔ Elevate one or two goals for specific emphasis.
✔ Decide on a measureable result and a time by when it is to be achieved.
✔ Investigate all best practice literature and solutions to understand the scope of the issue and gap analysis (For example, if studying S.S.I., investigate the national solutions available on the Joint Commission's Targeted Solutions Tool (T.S.T.)
✔ Select the leverage points that will move results toward the goal.
✔ Create leading measures of action on the leverage points—a scoreboard
✔ Ask team members to commit to actions that will move the levers.
✔ Hold weekly meetings/huddles with the team to review, renew, and commit to new actions.

References

1. Sutton L, Burck C, Charan R. *Execution: The Discipline of Getting Things Done.* New York City: Crown Business, 2002.
2. McChesney C, Covey S, Huling J. *The 4 Disciplines of Execution: Achieving Your Wildly Important Goals.* New York City: Free Press, 2012.

For More Information

1. Conner DR. *Leading at the Edge of Chaos: How to Create the Nimble Organization.* New York City: Wiley, 1998.
2. Franklin Covey Co. Execution in healthcare. 5 videos on patient satisfaction and cost savings and a 17-minute 4 Disciplines overview. Accessed May 16, 2013. http://www.franklincovey.com/4dhc/.

* The practices in this section are based on the book, *The 4 Disciplines of Execution: Achieving Your Wildly Important Goals.* Although we do not recommend or endorse any particular product or service from the authors or their company, the principles and disciplines of execution contained in the book have proven their effectiveness in health care settings and deserve careful consideration.

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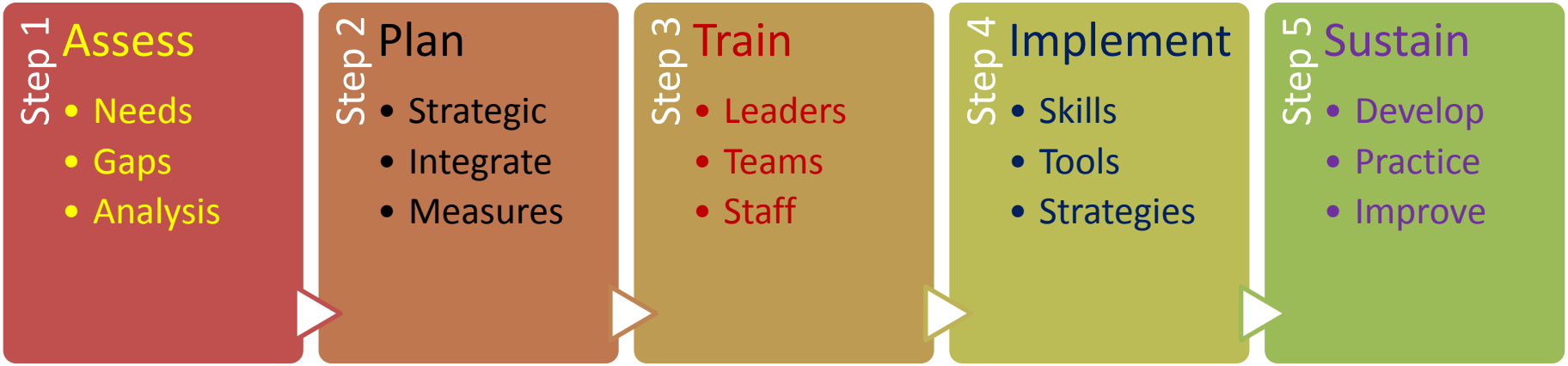
Case Study – Apply the 4 Disciplines

OSF Saint James – John W. Albrecht Medical Center

OSF
SAINT JAMES-JOHN W. ALBRECHT MEDICAL CENTER

Our Approach to Change



8 Steps of Change

John Kotter

Step 1: Create a Sense of Urgency

Sizing Up the Culture Exercise Sheet

INSTRUCTIONS:

As you answer the questions below, consider the state of your current organization and the current safety climate.

Step 1: A Sense of Urgency

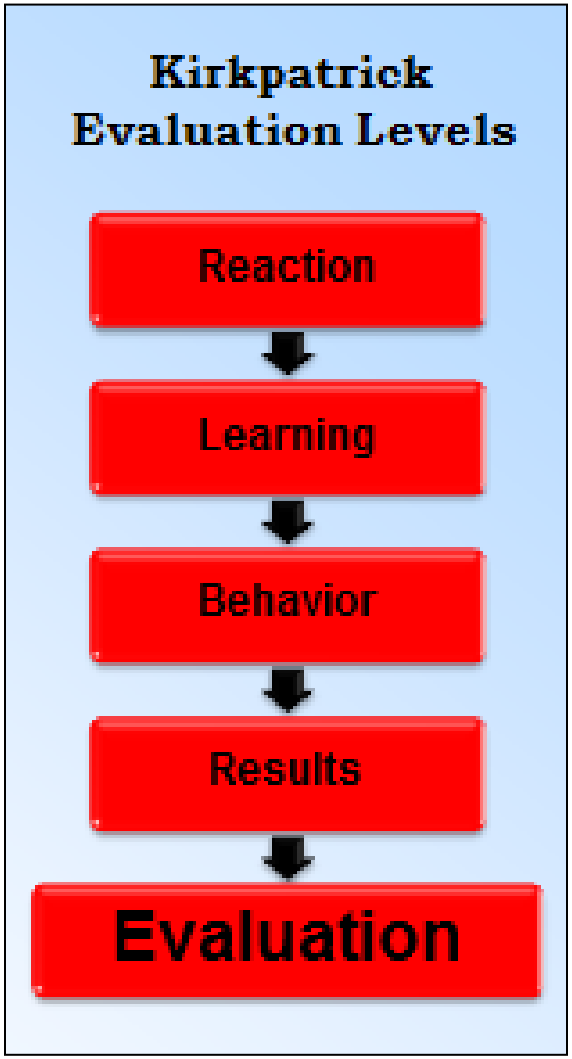
1. What information do you have that may indicate a need for change in your organization?

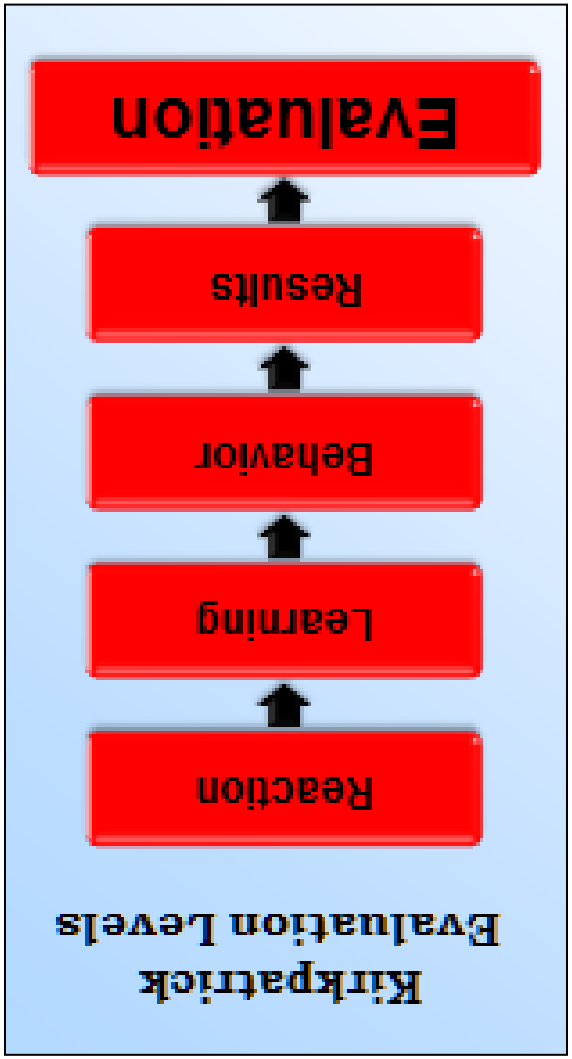
2. Where else might you look for "hidden" information?

3. How is the need for change communicated in your organization? What do you think is the most appropriate way to communicate the need for change?

4. What can *you* do to create a sense of urgency for change in the organization?

Measuring the success of your intervention





Measuring for Results

Recording Reported Harm Events

Check sheets are used by staff to indicate how many times (frequency) a particular incident occurred

Date of Month	Day of Month	Patient Falls	Medication Errors	Other Medication Incidents	Report of 9-10 on the Pain Scale	Incidence of Pneumonia Infections
1	Sun	I	I I	I I	I	I
2	Mon			I		
3	Tue				I I	I I
4	We				I I I I	I
5	Thu		I			I
6	Fri				I	
7	Sat	I I		I I	I I I I	I I I
8	Sun		I I I		I I	I I
9	Mon					I
10	Tue		I			

Detailed Data Logs

Data logs are used to track more detailed information about incidents.

Patient Falls Log

Pt ID	Age	Treated for	Date of Fall	Time of Fall	Location of Fall	Injury Yes/No	If Yes, What/ Where	Factors Contributing to Fall	Was Patient on Meds? Yes/No
1	45	Diabetes	1/1/10	7:30 am	Pt Room	No	--	Fainted near bed	Yes
2	34	Hypertension	1/7/10	4:40 pm	Pt Room	Yes	Elbow bruise	Dizzy from medications	Yes
3	76	Stroke	1/7/10	6:13 pm	Hallway	No	--	Unsteady gait	Yes
4	51	Diabetes	1/11/10	7:42 am	ER	No	--	Chair toppled	No
3	76	Stroke	1/15/10	11:20 pm	Bathroom	Yes	Hip fracture	Slipped near toilet	Yes
5	55	Heart attack	1/24/10	11:34 am	Hallway	Yes	Head laceration	Floors slippery- just waxed	Yes

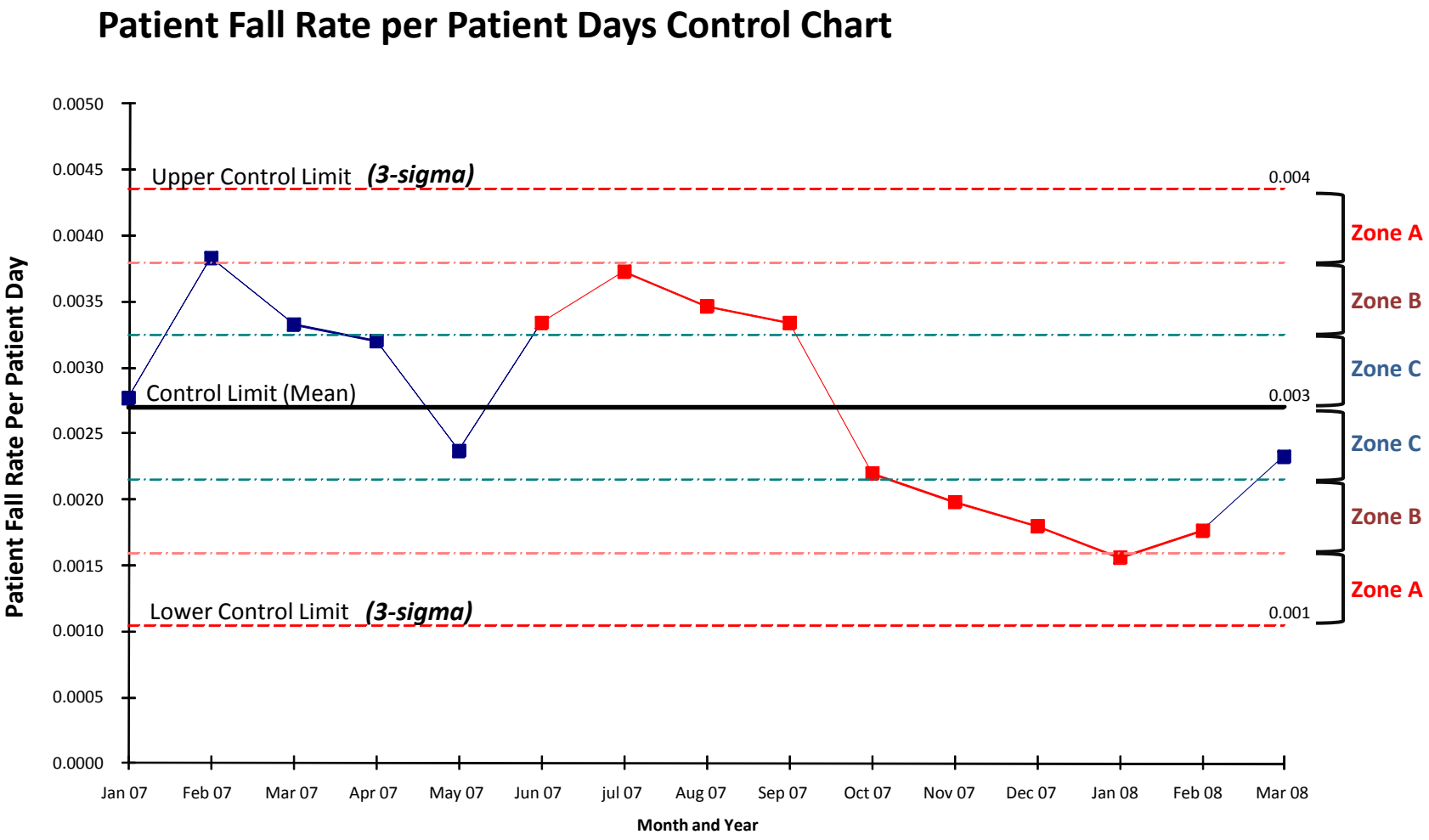
Proactive Audit Tools

Audit tools can be used to track compliance of standard processes to be followed.

Pain Assessment Audit

Audit Item	Yes	No	Not Applicable
Patient assessed for pain using standard pain scale	√		
Medications currently taken for pain documented		√	
If pain was expressed, interventions taken within 15 minutes	√		
Pain reassessment conducted within one hour after initial assessment		√	
Pain decreased on standard pain scale		√	
If pain did not decrease, appropriate follow-up done (reported to physician, etc.)	√		

Control Chart as Feedback Mechanism



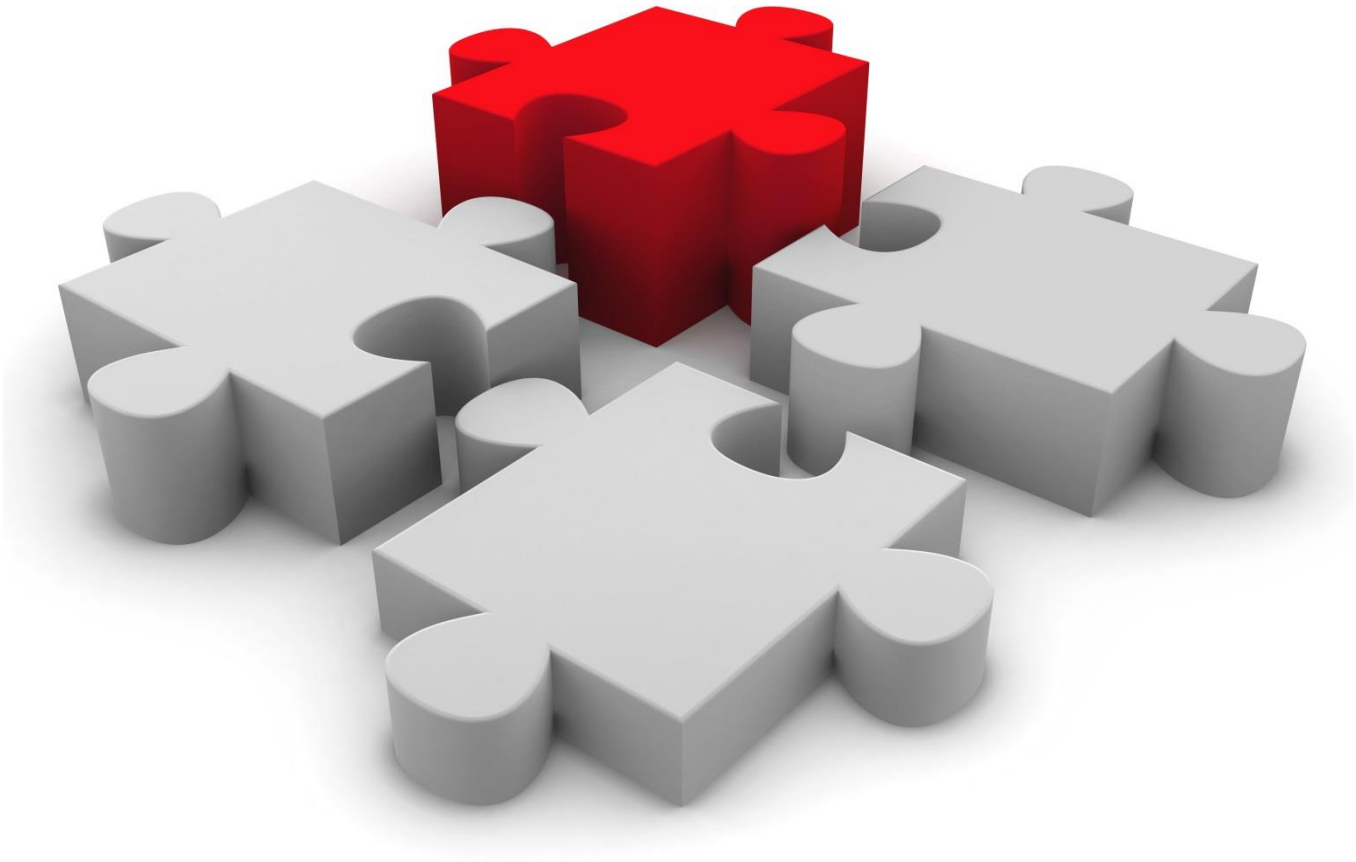
Learning from Defects

"The only real mistakes are the ones from which we learn nothing."

John Powell, ***Composer***

Summary

Connecting the Dots



Comments, Feedback, Questions, Evaluation