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Patient Safety. From Metaphor to Model: The Clarian Safe Passage Program

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From Metaphor to Model: The Clarian Safe Passage Program

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ABSTRACT:

The most important stakeholders in patient safety are alert and mobilized frontline health care staff. At Clarian Health Partners, Indianapolis, IN, clinicians in the Safe Passage Program work jointly with unit staff, physicians, and other departments to continuously improve the level of patient, employee, and visitor safety. Medical error reporting at Clarian has tripled. The enthusiasm and passion of Safe Passage clinicians is both inspiring and energizing.

IN THEIR RECENT ARTICLE, "Five Years After To Err is Human - What Have We Learned," Lucian Leape and Donald Berwick state that the most important stakeholders in patient safety are alert and mobilized frontline health care staff [Leape & Berwick, 2005). We agree.

From an administrator's view, truly engaging the frontline of patient care in patient safety is difficult to accomplish. Frontline participation takes time and money, and does not show clear and measurable results as a Six Sigma or performance improvement project would. Some successful frontline applications, such as crew resource management, can be expensive and difficult to apply throughout an organization.

To address this need for frontline patient safety experts, Clarian Health Partners has developed the Safe Passage Program. Based on the concept that patients experience "safe passage" through the health care system, the Safe Passage clinician is not only alert and mobilized, but also trained to understand and apply patient safety concepts. The role of the Safe Passage clinician, and how the role fits into the concept of a high reliability organization [HRO), is explored.

Key Elements of a HRO

Reliability is defined as the measurable capability of a process, procedure, or service to perform its intended function in the required time under commonly and uncommonly occurring circumstances (Berwick & Nolan, 2003). An HRO is an organization, such as an aircraft carrier or nuclear power plant, that is reliable and safe in even the most hazardous of circumstances. The HRO can teach health care many lessons. Unlike HROs, however, the health care work environment is highly complex, more diverse, and constantly changing. Additionally, due to individual practice issues, different patient and family constellations, and differing health care infrastructures, health care is difficult to standardize.

From professional organizations to state legislatures, external organizations have answered the call to improve patient safety. The Joint Commission on Accreditation of Healthcare Organizations, the Institute for Healthcare Improvement, Leapfrog and the National Quality Foundation, among others, have implemented major national patient safety initiatives. Additionally, many states have mandatory error reporting requirements. All reporting requirements are evidenced based and can actually improve reliability within a health care organization. However, these reporting requirements demand resources. Although necessary and helpful, mandatory reporting alone does not speak to all patient safety issues within a health care organization. The challenge is to balance and understand reporting requirements while attending to internal patient safety issues.

HROs hold a key to balancing patient safety mandates, design, and measurements. Gaba (2003) states that HROs have four key elements which may be used as criteria to balance a health care organization's patient safety initiatives.

1. Intact systems, structures, and procedures conducive to safety and reliability; for example, mandatory and voluntary patient safety reporting.
2. A culture of safety permeates the organization; this is the foundation of any patient safety program.
3. Safety and reliability examined prospectively for all the organization's activities; organizational learning by retrospective analysis of accidents and incidents is aggressively pursued as seen by Root Cause Analysis and Failure Mode Event Analysis.

4. Intensive training of personnel and teams takes place during routine operations, drills, and simulations (for example, crew resource management and mock codes).

A Culture of Safety Permeates the Organization: The Safe Passage Program

The term "safe passage" is coined from the American Association of Critical Care Nurses (AACN) Synergy Model of Patient Care. This model matches patient characteristics with nursing characteristics for optimal care. Its key outcome is that the patient experiences safe passage through the health care system (Curley, 1998). Clarian has implemented the AACN Synergy Model of Patient Care systemwide.

The Safe Passage Program grew from an idea to put a "safety nurse" on every patient care area. It was soon apparent that for a frontline, staff-driven program to work, the staff needed to understand key patient safety areas of study. Concepts such as work complexity, technology, communication, and teamwork are among those taught to new Safe Passage clinicians.

The Safe Passage clinician, designated by the unit to become the local safety expert, works jointly with unit staff, physicians, and other departments to continuously improve the level of patient, employee, and visitor safety. Goals of the Safe Passage Program include:

- Providing nurses with a patient safety knowledge base, including the most current patient safety information available.
- Providing a communication network from top to bottom and bottom to top; preventing errors through planning for change and identifying gaps.
- Creating a mechanism to analyze and learn from errors.
- Increasing work efficiency and effectiveness.
- Providing a mechanism for process improvement through evidence-based practice.

When these goals were first outlined and adopted, they seemed daunting. However, in the course of 4 years, the Clarian Safety Passage Council developed and incorporated these goals.

Infrastructure is key to the function of Safe Passage. Safe Passage members participate in a Clarian system-wide monthly meeting. This meeting provides an opportunity to share experiences and issues across units and departments and also acts as a vehicle for knowledge dissemination. Each Safe Passage member participates in a local monthly Safe Passage Council meeting. Safe Passage Councils include mother/baby, emergency and trauma center, Riley Children's Hospital, Indiana University Hospital, and Methodist Multi-specialty and Intensive Care. Educators, managers, and frontline staff facilitate the Safe Passage Councils. Other methods of communication include a listserv, newsletter, and Safe Passage Emergency Alerts.

Once the infrastructure and schedule were established, Safe Passage clinicians began to share near misses and error reporting across the Clarian system. Sentinel events and root cause analyses were discussed. Up-to-date research, patient safety news, and articles were shared and disseminated. Stakeholders from key initiatives requested time on Safe Passage agendas, not only to explain processes but also to receive feedback from the frontline perspective. Safe Passage clinicians were

selected for team memberships based on patient safety knowledge, systems thinking, and frontline perspective.

The link to operations is a work in progress. Safe Passage clinicians sit on Clinical Practice Councils and have time on unit agendas. Some unit newsletters include a "patient safety column" with up-todate patient safety information.

Knowledge Driven Care™

Clarian internal initiatives are producing a body of knowledge that helps identify opportunities for improvement in patient safety issues. This organization-specific knowledge, paired with evidence-based practice, allows improvements in care and is referred to as Knowledge Driven Care™.

Knowledge Driven Care™ represents a shift from reactive thinking and retrospective analysis to proactive planning and design. Safe Passage clinicians are able to anticipate patient safety issues based on need, experience, and expertise. One of the hallmarks of an HRO is deference to expertise, with leadership deferring to experts at the point of care (Weick & Sutcliff, 2001). Frontline staff see the patient safety landscape from a different level than leadership. Coupled with the Synergy Model of Patient Care, staff anticipate the needs of the patient based on nursing and patient characteristics.

Additionally, to achieve reliability, design must be linked with reliability science and human factors research. Berwick and Nolan (2003) state that there are three levels of safe systems of care: (a) to design the system to prevent failure; (b) to make failures visible so they may be intercepted before causing harm; and (c) to mitigate the harm caused by failures when they are not detected or intercepted.

Proactive Thinking on the Front Line

Kathy Shields, BSN, RN, is the Safe Passage clinician on the infant intensive care unit at James Whitcomb Riley Hospital for Children. After attending core curricula and the Riley and Clarian Safe Passage Councils, she returned to the unit in search of a project. Ms. Shields made rounds of the rooms and talked to her peers.

Ms. Shields noted that several rooms did not have the correct spare tracheostomy tubes cleaned and ready for use at the bedside. Although available in the unit, it is safer and quicker to have a set at the bedside. She further noticed that some of the rooms not only had the clinical alarms set in different ranges but also at limits that were either too high or too low to be helpful or safe. Based on this information and other safety issues, Ms. Shields created a checklist and started raising awareness by discussing the issues in the unit newsletter. She and other staff members audited the checklist and posted the results in the newsletter and on the unit. In a short time, the unit achieved 100% compliance. After several months at 100%, Ms. Shields noted that this was now a unit practice firmly imbedded in the culture. Now she occasionally monitors the safety list to check compliance; each spot check has revealed 100% compliance.

This shift to proactive thinking increased reliability on the infant intensive care unit. Staff can now be assured that they have the proper supplies and equipment at their fingertips, rather than searching for supplies in an emergency. Staff knows that because the alarm limits are consistently applied, they are

able to respond appropriately to alarms. Any one of these factors could be the root cause of an adverse event. Using the design of safe and reliable care, Ms. Shields and the infant intensive care unit designed a system to prevent failure as well as established procedures to make failures visible so they may be intercepted before causing patient harm.

This performance improvement project did not take an inordinate amount of time. Since the project was staff driven and all staff participated and recognized the need for reliability, the project went smoothly. Information was disseminated and used for improvement. There is no doubt that the project improved reliability on the unit.

Safe Passage Challenges, Growth, and Outcomes

When it was clear that the Safe Passage Program was a success, with eager and dedicated volunteers of many disciplines, we asked ourselves what made the program popular. The answer: it was about their work. The enthusiasm and passion of Safe Passage clinicians is both inspiring and energizing.

The Safe Passage Program is still maturing. The flexibility of the structure, while somewhat frustrating for those who like a structured process, allows the program to develop along with the clinicians. For example, at Indiana University Hospital, both the acute care and multi-specialty units had Safe Passage councils. After 2 years as separate councils, the staff decided to combine into the Indiana University Safe Passage Council. The merging of this group has been an effective way to share information regarding hand-offs, medication reconciliation, and other system and continuity of care issues.

Cost Factor

The largest single cost of Safe Passage is the time Safe Passage clinicians are off the unit for Safe Passage meetings and related activities. Additionally, time is required for unit activities and information dissemination. With that time, however, patient safety ideas, issues, and information are traveling faster and distributed broadly. Projects and information are shared on a system-wide basis, reaching more units for improvement activities.

From an outcome perspective, medical error reporting at Clarian has tripled. In concert with other initiatives at Clarian, such as Magnet designation and the Synergy Model of Patient Care, the nursing vacancy rate has decreased significantly. Work is underway to capture the patient safety issues that a Safe Passage clinician identifies, corrects, and/or requests system-wide help. These interventions are called "good catches." A form exists for staff to capture and report "good catches," but interventions are captured more effectively when included as part of the information sharing at each local and systemwide Safe Passage meeting. Staff-led performance improvement activities, such as the example noted previously, are very effective.

Conclusion

The Safe Passage Program illustrates the concept of "metaphor to model," where a perception or mental model is used to guide the evolution of the end product (Nonaka, 1998). The initial idea of the Safe Passage program was not to create a product that could be plucked off the shelf or plugged in a tool. The goal of the patient passing safely through the system provided staff with a common vision and the term "safe passage" shapes the program. From a leadership perspective, it was essential to

have the time to develop the program, when immediate results and fixes were not available. Culture change takes time.

The Clarian Safe Passage Program is a maturing frontline patient safety program. The evolution and advancement of the program takes patience, nurturing, and development by staff and leadership. The experience with Safe Passage illustrates the challenges and the fantastic rewards in implementing a staff-driven patient safety model. The need for frontline staff involvement in patient safety is not only evidence based, it is the right thing to do.

Executive Summary

- The most important stakeholders in patient safety are alert and mobilized frontline health care staff.
- At Clarian Health Partners, Indianapolis, IN, clinicians in the Safe Passage Program work jointly with unit staff, physicians, and other departments to continuously improve the level of patient, employee, and visitor safety.
- Medical error reporting at Clarian has tripled. The enthusiasm and passion of Safe Passage clinicians is both inspiring and energizing.

References

Berwick, D., & Nolan, T. (2003). High reliability health care. Retrieved October 2004, from http://www.ihi.org/IHI/Topics /Reliability/ReliabilityGeneral/EmergingContent/HighReliablityHealthCarePresentation.htm

Curley, M.Q. (1998). Patient-nurse synergy: Optimizing patients outcomes. American Journal of Critical Care, 7(1), 64-72.

Gaba, D. (2003). Safety first: Ensuring quality care in the intensely productive environment - the HRO Model. Anesthesia Patient Safety Foundation Newsletter, 28(1), 1-16.

Leape, L., & Berwick, D. (2005). Five years after To Err is Human: What have we learned? Journal of the American Medical Association, 293(19), 2384-2390.

Nonaka, I. (1998). The knowledge creating company. In Harvard Business Review on Knowledge Management (pp. 21-46). Boston, MA: Harvard Business School Publishing.

Weick, K.E., & Sutcliff, K.M. (2001). Managing the unexpected assuring performance in an age of complexity. San Francisco, CA: Jossey-Bass.

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