Take 3 – Practical Practice Pointers© November 4, 2019 Edition

The "Providing Safe Ambulatory Care" Edition

Follow-up Correction:

My thanks to those keen-eyed readers who noted that the definition of "severe" community-acquired pneumonia was incorrect in the October 28 Take 3. It was written as "one major and three minor criteria" whereas the definition is "either one major **or** 3 minor criteria."

From the ECRI Institute (fka "Emergency Care Research Institute")

1) Primer on Providing Safe Ambulatory Care

Creating a strong, nonpunitive culture of safety that encourages the reporting of patient safety events is one of the cornerstones of safe patient care. According to the Agency for Healthcare Research and Quality (AHRQ), a culture of safety encompasses the following features (AHRQ "Culture of Safety"):

- Acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- An environment where individuals can report errors or near misses without fear of reprimand or punishment
- Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- Organizational commitment of resources to address safety concerns

A necessary component of a culture of safety is maintaining an open, fair, and just culture. Such a culture does not dismiss accountability entirely, as clinicians and staff are still held responsible for reckless or willful disregard of protocols and procedures. However, a culture of safety embraces human fallibility and responds to unintentional errors, lapses, near misses, and adverse events with counseling or coaching depending on the circumstances, and a focus on systems issues and proactive solutions. This approach can help improve the quality and safety of care and can reduce the risk of similar errors occurring in the future.

Although a large majority of patient care in the US occurs in the ambulatory care setting, most studies around patient safety have focused on the inpatient setting. While many of these risks are shared by all healthcare settings, their presence in the ambulatory care setting poses some unique challenges. In October 2019, the ECRI Institute, an independent, nonprofit organization dedicated to improving the safety, quality, and cost effectiveness of care across all healthcare settings, released a report outlining safety risks that patients face in the ambulatory care setting. The data reported to the ECRI Institute's patient safety database are provided voluntarily and are based on spontaneous reports from staff. Based on an analysis of data reported between December 2017 and November 2018, they identified four key risks in the ambulatory

care setting and one area of concern along with key recommendations. Some of these included:

Diagnostic testing errors: These accounted for 47% of adverse events reported, with 69% involving laboratory tests, and 21% involving imaging tests.
Key Recommendations:

- Provide decision support tools to help providers order the proper tests.
- Establish a coverage chain of command for communicating test results that clearly outlines by job function who will receive the results and processes for communicating results to the covering provider, as well as who will accept results if both the ordering and covering provider are absent.
- Ensure that the tracking policy clearly identifies the provider who will receive and act on the results of any clinical test.
- Use technology to track test results and to help ensure follow-up.
- Educate staff about the organization's diagnostic testing policies and procedures.
- Implement processes to ensure that critical results are communicated immediately by direct verbal communication from the lab or testing center to the ordering provider. Critical results must not be communicated over voice mail or email or to administrative assistants or other unlicensed staff members.
- Implement and enforce a policy requiring staff to proactively communicate all diagnostic test results, including normal results, directly to the patient and to document when and how the notification occurred.
- Implement written standard operating procedures for specimen collection, preparation, and delivery.
- Educate patients on what tests are being ordered and the importance of following up on tests or recommended treatments.
- Monitor processes for test tracking and follow-up on a regular basis and make changes when necessary.

Medication safety events: These accounted for 27% of adverse events reported. Two thirds fell into the category of "wrong" errors; 34% were wrong-drug errors, 17% were drug overdose errors, and 16% were wrong-patient errors. Other errors included giving the drug at the wrong time, at the wrong rate, or at the wrong strength.
Key Recommendations

- Focus medication safety improvement efforts by identifying priority areas (e.g., medication-event identification and reporting, high-alert medications, medication safety education, the elimination or reduction of unclear abbreviations) and developing initiatives to address those areas.
- Establish and implement standardized policies and procedures that incorporate best practices and guidelines for each part of the medication management process.
- Establish standardized definitions for adverse medication events and near misses, and set a policy directing how to report and manage such events.
- Educate staff about the organization's medication policies and procedures,
- Provide information and training, as needed, when new drugs or medication-related technologies are adopted.
- Establish/communicate the process for vaccinations that covers everything from storage to administration and incorporates best practices/standards/guidelines.
- At each appointment, review, confirm, and enter into the patient's clinical record the following: the patient's medical history; age; height and weight; allergies; adverse

drug reactions; current medications (prescription and nonprescription), supplements, and alternative treatments; and any changes in prescription or nonprescription medication with name and dosage, when available.
- When administering medications, consider the seven “rights” of medication administration: right patient, right route, right dose, right time, right medication, right reason, and right documentation.
- Follow best practices when storing and handling medications.
- Educate patients and families on potential complications associated with the medications they are taking, and instruct them on what to do if a medication-related event occurs.

Falls: These accounted for 14% of events reported. Key Recommendations:
- Ensure that patients are screened for falls risk at every visit, when a change in condition is noted, and after a fall.
- Train staff to identify intrinsic and extrinsic factors related to fall risk when interacting with patients (e.g., welcoming, screening, and conducting an assessment).
- Ensure that a “flag” appears in the electronic health record to alert the ordering clinician that the medication carries a fall risk.
- Communicate to all staff members clear and consistent policies for documenting and reporting falls.
- Provide written fall prevention materials to patients and families.
- Offer patients the opportunity to talk about falls that have happened, and discuss their fear of falling; educate patients and families on the benefits of increased mobility and autonomy.
- Ensure that the patient’s risk of falling, and of sustaining a fall-related injury, is effectively communicated to the patient.
- Provide equipment to help prevent falls, such as grab bars and elevated toilet seats in all bathrooms and stable assistive devices in exam rooms.
- Conduct environmental rounds regularly both inside and outside the practice setting to identify and eliminate extrinsic risks that increase the risk of falls, such as equipment in poor repair, clutter, or inadequate lighting.

Security and safety incidents: These accounted for 5% of events reported.
Key Recommendations:
- Establish a comprehensive workplace violence prevention program and allocate sufficient resources to the program.
- Conduct an all-hazards risk assessment at least annually, incorporating patient-related risk factors, environmental risks, and operational risks to evaluate the potential for violence.
- At least monthly, conduct security and safety surveillance rounding.
- Provide staff with guidance on recognizing verbal and behavioral cues that suggest a patient could become combative.
- Train staff on how to respond to patients who have mental health conditions who exhibit disruptive behavior.
- Educate staff on appropriate and inappropriate techniques to handle aggressive behaviors (e.g., de-escalation techniques) and conduct simulation or role-playing exercises to train staff on the use of these de-escalation techniques.

- Conduct workplace violence training drills (e.g., locate safe exits, help patients escape, summon assistance, map out various responses to an assailant who is using a gun, knife, or fists)
- Ensure that all physicians, clinicians, and staff are educated regarding the organization's code of conduct.
- Communicate the organization's philosophy prohibiting harassing behavior.
- Educate staff on how to identify and respond to a patient or family member's discriminatory behavior (e.g., sexual harassment or discrimination based on age, sex, race, ethnicity, or sexual orientation).
- Educate staff about the importance of reporting discriminatory behavior or incidents of workplace bullying, threats, or violence whether perpetrated by patients, visitors, clinicians, or staff.
- Explain the protection from retaliation offered to those who report a coworker's harassing, demeaning, bullying, threatening, or violent behavior.

HIPAA Violations: Though not considered a direct patient safety concern, the report noted concern around an understanding of HIPAA regulations and recommended organizations conduct a privacy and security risk assessment and act to resolve gaps in workflow and health information technology security as well as initial and ongoing staff training regarding the handling of a patient's medical record information.

My Comment:
In my role co-chairing the Carilion Clinic Ambulatory Clinical Advancement and Patient Safety committee (A-CAPS) as well as my work chairing our departmental Peer Review committee, I've become much more aware of the "themes" regarding patient safety and care quality issues in the ambulatory setting. This is something for which most of us had very little education during our medical training, and yet they have substantial impact in terms of healthcare outcomes. The two that I see most often are widely varied and inconsistently implemented processes for laboratory/imaging reporting to patients (closing the communication loop) and poorly designed and/or implemented medication reconciliation processes. As outlined in the report, more effectively addressing these alone would eliminate the vast majority of safety events in the ambulatory setting.

We have the opportunity to lead these efforts as we together help to create and advance the "science" of the provision of ambulatory care. Ultimately, the quality of care we provide will be measured by the outcomes of that care. This includes not only practicing evidence-based medical care, but also studying the processes of how that care is delivered and implementing evidence-based team care practices. It's a young science, and together we have the opportunity to make a significant positive impact.

Reference:
ECRI Institute PSO "Deep Dive – Safe Ambulatory Care." October 2019. Report

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

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