The George Washington University Hospital & Graduate Medical Education

Quality & Patient Safety
Introduction

• Quarterly Quality & Patient Safety Discussion
  – IHI Open School
  – GWUH occurrences
• Involvement in hospital quality, patient safety, patient satisfaction initiatives
• Hospital sponsorship of quality and patient safety focused projects
• Case of the month beginning in October 2013
Innovation & Care at GWUH

• High Tech & Innovative Care
  – Cardiac Catheterization via the Radial Artery
  – Minimally invasive, robotically-assisted surgery
  – Designated Level 1 Trauma Center
  – ECMO
  – Minimally Invasive Spinal Surgery
  – Bone Marrow Transplant
  – Bariatric Surgical Center of Excellence
  – Primary Stroke Center
Cost of Non-Quality

• In U.S. Healthcare system
  – 7% of patients suffer a medication error
  – On average, every patient admitted to an ICU suffers an adverse event
  – 44,000-98,000 people die in hospitals each year as the result of medical errors
  – Nearly 100,000 deaths from HAIs
  – Estimated 30,000 to 62,000 deaths from CLABSI
  – Cost of HAIs is $28-33 billion
“Every system is perfectly designed to achieve the results it achieves”

*Don Berwick’s Central Law of Improvement*
Swiss Cheese Model of Harm

Patient suffers

Swiss Cheese Model of Harm

- Inadequate training and supervision
- Communication between Resident and Nurse
- Patient suffers
- Venous air embolism
- Lack of protocol for catheter removal
- Catheter pulled with Patient sitting

References:
FACT #1: We work in a profession that demands perfection

FACT #2: We are all inherently fallible human beings
**TRUTH:** No human is perfect; we all make mistakes

• We must understand the difference between:
  – Human error
  – At risk behavior
  – Reckless behavior

• How do we tell the difference?
Did they intend to cause harm?
Did the come to work impaired?
Did they do something they knew was unsafe?
Could 2-3 peers have made the same mistake in similar circumstances?
Do they have a history of involvement in similar events?
Creating a Culture of Safety

• What is a culture of safety?
  – Psychological Safety
  – Active Leadership
  – Transparency
  – Fairness

• Creation of a non-punitive response to error
Learn to “Stop Takeoff”
Fatal Aviation Accidents per 1 Million Departures
If you haven’t done so already, please:

– Complete the pre-survey (survey monkey) ASAP
– Register on IHI Open School

Following this presentation, complete IHI Open School course - PS 106

– December 2013 GME - PS 103
– March 2014 GME – PS 105
– June 2014 GME – QI 102