

Duke Infection Control Outreach Network (DICON) Patient Safety Program Summary Report for the period February 6, 2004 to August 24, 2005

In January 2003 the Duke Infection Control Outreach Network (DICON) initiated a program designed to improve the patient safety and minimize medical errors in a pilot project involving two DICON-affiliated hospitals. This collaborative safety program has subsequently grown and expanded to involve four community hospitals. The goals of the DICON safety program include the following:

- Develop mechanisms to identify and implement practical and specific processes that minimize medical errors.
- Increase awareness of error prevention strategies through education and through the example of ongoing detection and resolution of patient safety issues
- Develop screening tools that identify causes of errors in community hospitals
- Facilitate compliance with JCAHO and other regulatory agencies in community hospitals

Each hospital participating in the DICON safety program has formed a safety team that makes “walk rounds” on a regular basis. Safety teams are typically comprised of a safety officer or a risk manager, a pharmacist, a senior member of the hospital administrative staff and a representative from the hospital quality improvement or education program. Although unit managers sometimes attend safety walk rounds, they are not required to do so as the primary goal of the safety team is to communicate with primary caregivers and other hospital employees in order to understand and solicit information from “ground level” personnel. Members of the safety team collectively interview one or more hospital staff on each safety walk-round. Data and comments from these structured interviews are then entered into a database developed by DICON. This database allows the safety team to categorize general areas of safety-related concern and develop feedback “loops” to

resolve problems related to patient safety. Comments and answers from interviews are recorded, categorized and scored according to risk, probability and severity. We calculate a hazard score that quantitates the degree of risk or safety concerns and establishes priorities for resolution of safety issues. The DICON safety database also automatically generates worksheets that identify and track unresolved or “open” issues related to patient safety.

This report summarizes data collected at participating hospital safety rounds during the period February 6, 2004 to August 24, 2005.

During the past 18 months a total of 44 patient safety rounds were performed in four DICON-affiliated hospitals. A total of 100 interviews were completed and 242 safety-related problem issues were identified. The average hazard score for these problems was 6.3. The most common category of concern related to patient safety detected in these 100 interviews were as follows:

- Communication (91)
- Equipment (45)
- Staffing (32)
- Medicines (20)

Hazard scores by category are shown in the attached graphs.

Approximately 34% of the 242 issues identified during safety rounds were resolved during the past 18 months. An additional 13% were closed but not resolved and 53%

remained as open (unresolved) safety issues. The proportions of safety issues successfully resolved varied from ~ 50% to ~ 25% in individual hospitals.

Approximately one-half of the employees who were interviewed during patient safety walk rounds stated that they were unaware that the hospital administration and leadership was dedicated and committed to the development of a “blame-free” culture. In 2 of the 4 hospitals less than half of the employees responded affirmatively to questions about their awareness of a goal of a blame-free culture.