The “3Cs” of Patient Safety

A recent case involved a patient who underwent a radical prostatectomy due to mistakenly switched biopsy specimens. The actual specimens were benign, and the patient now suffers from permanent erectile dysfunction. An investigation revealed a mix-up in the biopsy trays which was disclosed to the patient.1

When mistakes occur in medicine, we often focus on the risk management and patient safety aspects of the case and fail to consider the physician or staff member involved in the mistake. The last thing any clinician wants is to injure a patient; but how can you prevent human errors from occurring in the first place? The “3Cs” of Patient Safety—Culture, Communication, and Checklists—may offer some solutions.

Culture

While preventing all adverse events and medical errors is nearly impossible, by adopting characteristics of high reliability organizations (HROs), physicians may be able to significantly decrease medical errors. HROs—e.g. commercial aviation and nuclear power facilities2—consistently minimize adverse events despite complex and hazardous work. They develop systems that maintain a commitment to safety at all levels of the organization.

Safety-oriented cultures include the following key features:

• Universal acknowledgment of the high-risk nature of the organization’s activities and the determination to achieve consistently safe operations;

• A blame-free environment in which staff (regardless of their position) are able to report errors or near misses without fear of retaliation;

• Collaboration across rank to seek solutions to patient safety problems; and

• Organizational commitment of resources to address safety concerns.

HROs also anticipate the worst and provide both reminders and tools to keep staff vigilant.3

Pathways for Patient Safety™—a series of web-based modules developed to educate and implement best practices to reduce harm in physicians’ practices—identifies three crucial elements to sustain a patient safety culture:4

1. Leadership that ensures patient safety is a top priority;

2. Rewards and recognition used to reinforce safe behaviors; and

3. Open communication where employees are encouraged to speak up about unsafe practices.

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COMMUNICATION (Teamwork)

Communication breakdowns are one of the primary root causes of sentinel events identified by The Joint Commission from 2009-2011. An analysis of closed ambulatory care malpractice claims indicates over half of the $1.74 billion paid to plaintiffs was attributed to a failure in teamwork. Additionally, the likelihood of error decreases when physicians and staff respect each other and work as a team. TeamSTEPPS®, an evidence-based system designed to improve communication and teamwork, identifies four specific teamwork skills:

1. Leadership — empower team members to speak freely and ask questions
2. Communication — verifying information communicated
3. Mutual support — providing timely and constructive feedback to team members
4. Situation monitoring — identifying equipment problems

Checklists

The third and final “C” is checklists. Peter Pronovost, M.D., a critical care specialist at Johns Hopkins, is an instrumental force behind using checklists to simplify complex medical procedures and make them less error-prone. Checklists serve as a cognitive net, catching mental flaws inherent in all of us. The World Health Organization’s Surgical Safety Checklist is one of the most widely recognized checklists.

Just as checklists have been successfully used in the hospital setting, physicians’ practices can also benefit from their use. ProAssurance insured physicians and practice management professionals can access sample checklists for informed consent, assessing staff competency, office-based surgical procedures, and more at ProAssurance.com. For help with registration, email registration@proassurance.com.

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Is There a Robot in the House?

...telerounding with robots increased examination thoroughness, strengthened physician-patient continuity of contact, enabled more face-to-face discussions, and improved coordination of postoperative care.

Research

Studies show that half of hospitalized patients prefer seeing their own physician via robot versus seeing another physician in person. Another study reported that 24 percent of weight-loss surgery patients at Sinai Hospital in Baltimore spent less time in the hospital when a robot was used. The University of California, Los Angeles (UCLA) found that using robots resulted in shorter patient stays, decreased costs, and increased ICU capacity by 11 percent. A second ICU study found that telerounding with robots increased examination thoroughness, strengthened physician-patient continuity of contact, enabled more face-to-face discussions, and improved coordination of postoperative care.

Risk Management

While initial studies are promising, any new technology has potential risk. If you are considering robotic telemedicine, we encourage you to:

- Notify your local ProAssurance underwriting office to ensure insurance coverage;
- Determine whether licensing requirements mandate medical licensure in your home state and states where patients are located;
- Work closely with hospital staff to address credentialing and privileging issues (the Centers for Medicare & Medicaid Services recently revised Conditions of Participation allow treating telemedicine facilities to rely on the credentialing and privileging of remote facilities as long as certain conditions are met);
- Ensure patients understand the risks, benefits, and limitations associated with robot-assisted telemedicine;
- Document patient encounters in the medical record. Consider supplementing the record with photographs or segments of videotaped consultations. Establish storage and retrieval procedures for audio and video records;
- Develop equipment back-up procedures; and
- Work with information technology personnel to ensure HIPAA compliance and security of protected health information.

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