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The Physician Practice Patient Safety Assessment

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Supported by a grant from the The Commonwealth Fund

The Physician Practice Patient Safety Assessment™

The purpose of the Physician Practice Patient Safety Assessment™ is to heighten physician practices' awareness of distinguishing characteristics of a safe physician practice, and create a reference point and baseline for practice efforts to enhance and support patient safety .

Development of the *Physician Practice Patient Safety Assessment™* was supported by a grant from The Commonwealth Fund. The design of the assessment instrument reflects the judgment of its authors and does not necessarily represent the position of the Commonwealth Fund.

By completing this assessment, your practice could benefit by enabling safer and better care, reducing liability exposure and facilitating conversation and dialogue among staff and physicians to identify opportunities to increase patient safety.

Please read and review the self-assessment and the directions in their entirety *before* beginning the assessment process.

Confidentiality

This self-assessment will be completed by physician group practices and their results submitted to an aggregate database via a secure Web site (see below) at the MGMA Center for Research. All responses to this self-assessment will be kept confidential by the MGMA Center for Research. Aggregate results will be used for research, education, and improvement purposes, including feedback to practices that respond to the survey, and only aggregated results will be published or otherwise distributed. You will be asked to enter an ID code designating each specific practice or location, which will allow you to submit a separate analysis for each clinical site or location of your practice.

Feedback of Aggregate Results to Responding Practices

Each practice should retain a paper copy of its completed self-assessment in order to compare the practice's responses to the aggregate comparative results. It will be important that each participating practice determine areas where safety could be improved and consider changes to improve patient safety and to reduce the practice's risk of potential malpractice liabilty.

The PPPSA team does not represent – independently or collectively – a standard setting organization. As such, the assessment characteristics in this document are not purported to represent a minimum standard of practice and should not be considered as such. In fact, some of the assessment criteria represent innovative practices and system enhancements that are not widely implemented in physician practices today. Their value in reducing errors is grounded in scientific research and expert analysis of medical errors and their causes and they are provided as "stretch goals" for higher achievement in patient safety.

Instructions for Conducting the Physician Practice Patient Safety Assessment™

1. Establish a multidisciplinary team for each practice site consisting of, or similar to, the following:

- Medical director or other physician
- Administrator or office manager
- Nursing supervisor or nurse clinician
- Nonphysician provider
- Laboratory supervisor

- Radiology / imaging supervisor
- Pharmacist
- Risk manager
- Administrative support staff member

Smaller practices will have a smaller team since one person may fill several of these roles.

Depending on the services provided by the practice site, other staff members may need to join the core team for evaluation of certain sections of the self-assessment. For example, you may want to invite laboratory or radiology technicians to the meeting in which elements of testing procedures are discussed.

Your team should be provided with sufficient time to complete the assessment and be charged with responsibility to evaluate, accurately and honestly, the current status of safety practices in your facility. Because medical care is a complex, interdisciplinary process, the value and accuracy of the assessment is significantly reduced if it is completed by a practice manager or other individual acting alone. You may wish to schedule several short meetings with the team rather than try to complete the entire assessment at one meeting.

2. Read and review the self-assessment and the directions in their entirety before beginning the assessment process. The team leader should print this PDF version of the self-assessment and make copies of the assessment and send them to team members for review before the first team meeting. After the team has completed the paper self-assessment instrument, the team leader or designee is asked to input the results into the identical Web version of the assessment items (see below).

3. Complete the "Demographic Information." The team leader – if not the practice administrator or manager -- should verify the responses in this section with administration.

4. Convene the team. It is important to use this opportunity to critically assess the current realities of the practice as identified by the team. Viewing the tool through "rose colored glasses" will minimize the learning opportunities presented by the assessment process.

5. Discuss each key area and evaluate the practice's current success with implementing the assessment items. When a consensus on the level of implementation for each assessment item has been reached, place a check mark (✓) in the appropriate column using the following scoring key below. If scoring on an item cannot be agreed upon consider further investigation to verify the level of implementation and involve other healthcare practitioners outside your team to assist in the investigation. Return to those items at another meeting.

6. Go to the online assessment and input the results for the practice. Once the team has completed all the items in the assessment, the team leader or designee is asked to input the results into the Web version of the assessment at **http://www.PhysicianSafetyTool.org**. The items are identical in the PDF/ paper version of the instrument and on the Web. The respondent will be asked to enter an ID code to identify the particular practice or site The ID code can be

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purchased through the web site and grants users access to the online assessment, and will also enable you access to your questionnaire after it has been partially or completely answered and to the results comparitive results once it has been completed.

8. Review your practice's results in comparison to the aggregate results. When you have completed input of your results, you will be able to print out from the website your own answers, the aggregate results for other practices who have completed the assessment, and a PPPSA Workbook. We suggest that, using the PPPSA Workbook, you compare your results to the aggregate results to identify areas where you may wish to improve patient safety. The Workbook also provides resources available at a number of patient safety web sites that can be used to improve particular areas in the practice.

If you have questions or need more information, please contact John Mendez, MBA toll-free at 877.275.6462, ext. 880 or email us at <u>pmr@mgma.com</u>. We also welcome your comments on the self assessment tool and the self assessment project.

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Assessment Development Team

The Physician Practice Patient Safety Assessment™

Practice Demographics Section

1. Write down your ID code for each practice location that you will assess.
When you access the Web site, you will be asked to enter your ID code, and that will enable you to return to complete entering your results if you need to do that and access current results. If you do not already have an ID code, it can be purchased through the Web site www.PatientSafetyTool.org.

ID _____

2. Which of the following statements best describes your health care organization? (*Required)
❍ Free standing, independent medical group [go next to question 2A]
❍ Medical practice component of hospital integrated delivery system (IDS) [go next to question 2A]
❍ Freestanding ambulatory / urgent care center [go next to question 3 and skip question 2A]
❍ Hospital-owned ambulatory / urgent care center [go next to question 3 and skip question 2A]
❍ Federally Qualified Health Center, community health center or similar practice [go next to question 3 and skip question 2A]
❍ Certified Rural Health Center or similar practice [go next to question 3 and skip question 2A]
❍ Medical school faculty practice plan [go next to question 3 and skip question 2A]
❍ Medical school clinical science department [go next to question 3 and skip question 2A]
❍ Other _____ [go next to question 3 and skip question 2A]

2A. What best describes your type of practice?
❍ Multispecialty [go next to question 3]
❍ Single-specialty medical practice [go next to question 2B]

2B. What is the specialty of your practice?
Specialty _____

3. How many full-time equivalent (FTE) physicians are in your health care organization? (*Required)
Organization FTEs _____

3A. How many FTE physicians are in your practice / location? (*Required)
Location FTEs _____

4. How many FTE nonphysician providers are in your health care organization? (*Required)

Organization nonphysician provider FTEs _____

4A. How many FTE nonphysician providers are in your practice / location? (*Required)

Location nonphysician provider FTEs _____

5. What best describes the majority owner of your practice? (*Required)
- ○ Government
- ○ Hospital/integrated delivery system (IDS)
- ○ Insurance company or HMO
- ○ Management Services Organization (MSO) or Physician Practice Management Company (PPMC)
- ○ Physicians
- ○ University or medical school
- ○ Organizational component of an academic medical institution
- ○ Other _____

6. Which of the following statements best describes how your practice relates to other health care organizations? (*Required)
- ○ Free standing, independent of hospitals, other medical groups, government entities, and other health care organizations
- ○ Component of hospital or IDS
- ○ Practice is independently owned and managed but with a contractual relationship with outside organization(s) that provide guidance or information on patient safety
- ○ Other _____

7. Which is the legal organization of your practice? (*Required)
- ○ Business corporation
- ○ Limited liability company
- ○ Not-for-profit corporation/foundation
- ○ Partnership
- ○ Professional corporation/association
- ○ Sole proprietorship
- ○ Other _____

8. Which population designation best describes the area surrounding the primary location of your practice? If your practice had multiple sites, choose the option that represents the location with the largest number of FTE physicians. (*Required)
- ○ Nonmetropolitan (10,000 or less)
- ○ Nonmetropolitan (10,001 to 20,000)
- ○ Nonmetropolitan (20,001 to 50,000)
- ○ Metropolitan (50,001 to 250,000)
- ○ Metropolitan (250,001 to 1,000,000)
- ○ Metropolitan (more than 1,000,000)

9. Who participated in completing the *Physician Practice Patient Safety Assessment*™ for the specific practice / location? *(Select all that apply)* (*Required)
- ❑ Medical director or physician
- ❑ Administrator or office manager
- ❑ Nursing supervisor or nurse clinician
- ❑ Nonphysician provider
- ❑ Laboratory supervisor
- ❑ Radiology / imaging supervisor
- ❑ Pharmacist
- ❑ Risk manager
- ❑ Administrative support staff member
- ❑ Other _____

10. Is your health care organization accredited by a national organization or in the process of being accredited? (*Required)
- ○ Yes, the health care organization is accredited [go next to question 10A]
- ○ The health care organization is in process of being accredited [go next to question 10A]
- ○ No, the health care organization is not accredited or in process of accreditation [go next to question 11]

10A. Who is the accrediting entity? (Select all that apply)
- ❑ American Association of Accreditation for Ambulatory Surgery Facilities (AAAASF)
- ❑ Accrediting Association for Ambulatory Health Care (AAAHC)
- ❑ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ❑ National Committee for Quality Assurance (NCQA)
- ❑ Other _____
- ❑ Not Sure

11. What is your organization's senior administrator's current status/credential in the following associations? (Select all that apply.) (*Required)
- ❑ American College of Medical Practice Executives (ACMPE): Nominee
- ❑ ACMPE: Certified Medical Practice Executive (CMPE)
- ❑ ACMPE: Fellow in the College of Medical Practice Executives (FACMPE)
- ❑ American College of Healthcare Executives (ACHE): Member
- ❑ ACHE: Diplomate (Certified Healthcare Executive, CHE)
- ❑ ACHE: Fellow of the American College of Healthcare Exectuives (FACHE)
- ❑ American Academy of Medical Administrators (AAMA): Member
- ❑ AAMA: Credentialed Member of the American Academy of Medical Administrators (CAAMA)
- ❑ AAMA: Fellow of the American Academy of Medical Administrators (FAAMA)
- ❑ Affiliated with another association -specifiy:_____
- ❑ Not affiliated with a professional credentialing and certification association

12. How many days per week and total hours per week is the specific practice / location open for general patients?
Days per week _____

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Hours per week _____

13. Which of the following satisfaction surveys are routinely performed in the specific practice / location? (Select all that apply) (*Required)
❑ Patient satisfaction
❑ Employee satisfaction
❑ Physician and/or provider satisfaction

Current Level of Information Technology Adoption

14. What best describes the <u>consult tracking system</u> currently used for the majority of patients served by the specific practice / location?
○ Manual system that tracks if a consult was requested and if a consulting physician's report was received
○ Computerized system that tracks if a consult was requested and if a consulting physician's report was received
○ Combination of manual and computerized systems
○ Practice does not track referrals
○ Other _____

15. What best describes the <u>clinical laboratory *order entry* system</u> currently used for the majority of patients served by the specific practice / location?
○ Manual system using paper forms, fax and telephone requests
○ Computerized system that uses computer terminals, PDAs or other electronic means to order laboratory tests
○ Combination of manual and computerized systems
○ The practice / location does not order clinical laboratory tests
○ Other _____

16. What best describes the <u>clinical laboratory *results* system</u> currently used for the majority of patients served by the specific practice / location?
○ Manual system using paper documents, fax and telephone responses
○ Computerized system that uses computer terminals, PDAs or other electronic means to receive laboratory test results
○ Combination of manual and computerized systems
○ The practice / location does not receive clinical laboratory test results
○ Other _____

17. What best describes the <u>radiology / imaging *order entry* system</u> currently used for the majority of patients served by the specific practice / location?
○ Manual system using paper documents, fax and telephone requests
○ Computerized system that uses computer terminals, PDAs or other electronic means to order radiology / imaging procedures
○ Combination of manual and computerized systems
○ The practice / location does not order radiology / imaging studies
○ Other _____

18. What best describes the <u>radiology / imaging *results* system </u>currently used for the majority of patients served by the specific practice / location?
- ○ Manual system using paper documents, fax and telephone requests
- ○ Computerized system that uses computer terminals, PDAs or other electronic means to receive radiology / imaging procedures
- ○ Combination of manual and computerized systems
- ○ The practice / location does not receive radiology / imaging studies
- ○ Other _____

19. What best describes the <u>prescription writing system</u> currently used for the majority of patients served by the specific practice / location?
- ○ Manual system using paper documents, fax and telephone requests
- ○ Computerized system that uses computer terminals, PDAs or other electronic means to write a prescription
- ○ Combination of manual and computerized systems
- ○ The practice / location does not write prescriptions
- ○ Other _____

20. What best describes the <u>prescription refill system</u> currently used for the majority of patients served by the specific practice / location?
- ○ Manual system using paper documents, fax and telephone communications
- ○ Computerized system that uses computer terminals, PDAs or other electronic means to communicate with a pharmacy to refill a prescription
- ○ Combination of manual and computerized systems
- ○ The practice / location does not refill prescriptions
- ○ Other _____

21. What best describes the <u>drug interaction warning system</u> currently used for the majority of patients served by the specific practice / location?
- ○ Manual system using publications (Physicians Desk Reference, reports from pharmaceutical companies, etc.)
- ○ Mandatory use of computerized system that uses computer terminals, PDAs or other electronic means
- ○ Voluntary use of computerized system that uses computer terminals, PDAs or other electronic means
- ○ Verification with manual chart review
- ○ Combination of manual and computerized systems
- ○ The practice / location does not routinely screen for drug interactions
- ○ Other _____

22. Describe how the <u>health/medical records system</u> stores information for the majority of patients served by the specific practice / location. If the specific practice / location uses multiple technologies choose the system used for the majority of your patients' medical records.

- ❍ Paper medical records/charts filed in record cabinet
- ❍ A scanned image of a paper medical record/chart filed electronically using a document imaging management system (DIMS)
- ❍ An electronic health record (EHR) that stores patient medical and demographic information in a data base accessible by computer terminals or other electronic means. An EHR may also incorporate features of a DIMS.
- ❍ Other _____

23. As of today, what is your degree of EHR implementation for the specific practice / location?

- ❍ Fully implemented for all physicians
- ❍ Implementation in process or EHR is fully implemented for a portion of practice physicians
- ❍ Implementation planned in next 12 months
- ❍ Implementation planned in next 13 to 24 months
- ❍ Process has not yet started

24. Estimate the percentage distribution of patient ethnicity for the specific practice / location.

White, not of Hispanic origin	_____
White, Hispanic origin	_____
Black	_____
Asian or Pacific Islander	_____
American Indian, Eskimo, Aleut	_____
Other	_____
Total	100%

25. Estimate the percentage distribution of your patients' ages for the specific practice / location.

Infant (under 2 years of age)	_____
Pediatric (between 2 and 12 years of age)	_____
Adolescent (between 13 and 17 years of age)	_____
Adult (between 18 and 64 years of age)	_____
Geriatric (between 65 and 79 years of age)	_____
Aged (80 years of age and older)	_____
Total	100%

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26. Estimate the percentage distribution of your patients' primary languages for the specific practice / location.

English	_____
Spanish	_____
European other than Spanish	_____
Asian or Pacific Islander	_____
American Indian, Eskimo, Aleut	_____
Other	_____
Total	100%

27. Estimate, for the specific practice / location, the patients' level of literacy (in the patients' primary language, not necessarily English)

Illiterate, unable to read	_____
Reading ability less than 8th grade level	_____
Reading ability at 8th grade level or higher	_____
Total	100%

28. Estimate the percentage of the specific practice / location's "total gross charges" by type of payer.

Medicare	_____
Medicaid	_____
Commercial fee-for-service	_____
Commercial capitated	_____
Workers' compensation	_____
Charity and uncompensated care	_____
Self pay	_____
Other	_____
Total	100%

Scoring

Please use the scoring key on this page to complete the <u>Assessment of Practice Safety Section</u>, which comprises the rest of the assessment.

Scoring Key

A.   Unaware of this issue or aware but there has been <u>no activity</u> to implement this item.

B.   This item has been <u>formally discussed and considered, but it has not been implemented</u>.

C.   This item has been <u>partially implemented in the practice for some areas, patients, drugs, procedures, and or staff</u>. (For example, the practice is beginning a disease management program for its diabetic patients, but only new patients are currently enrolled.)

D.   This item is <u>fully implemented in the practice for some areas, patients, drugs, procedures, and or staff. </u>(For example: some patients are enrolled in a disease management program but other patients with chronic diseases are not enrolled in a disease management program.)

E.   This item is <u>fully implemented in the practice for all areas, patients, drugs, procedures, and or staff</u>.

N/A.   This item is not applicable to our practice. (This choice is available for certain items and includes a specific definition.)

Important Scoring Guidelines

For all assessment items: Unless otherwise stated, assessment items refer to policies, protocols, or procedures, medications, patients, and staff typically seen and treated in most practices. See answering N/A, below, for items not applicable to your practice.

For assessment items with multiple components: Full implementation (score D or E) should be selected only if all components are present in some (D) or all (E) areas of the practice. If only one or some of the components have been partially or fully implemented in some or all areas of the practice, assessment scores should not exceed level "C."

For assessment items that offer an option for "Not Applicable" (N/A): Select "Not Applicable" only if the item does not correspond to <u>any</u> patient types (e.g., pediatrics), procedures, medications, or other services you provide in your practice. A specific definition for the items in which this choice appears is included with the item.

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Assessment of Practice Safety

29. MEDICATIONS

There are a number of risks to patient safety related to various aspects of medication use. Because this is the area of patient safety most thoroughly studied, this section includes a large number of items.

A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

	A	B	C	D	E	N/A
29.1: A complete medication history including over-the counter medications, vitamins and herbal products is obtained and documented on every patient during each office visit.	❍	❍	❍	❍	❍	
29.2: Up-to-date, useful written information about medications is available to patients of the practice who do not speak English.	❍	❍	❍	❍	❍	
29.3: Patients are provided with an up-to-date list of all medications they are receiving upon leaving the practice or encounter (e.g., on a convenient wallet reference card).	❍	❍	❍	❍	❍	
29.4: A system is in place to track all patients receiving warfarin therapy that includes notices to patients for periodic laboratory testing of INRs and a documented review of INRs before prescription renewals are approved. (If you do not prescribe warfarin for any patients in your practice then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍
29.5: All prescriptions are entered into an office-based electronic prescribing system that produces either a computer-generated prescription or electronic transmission of the prescription directly to a pharmacy.	❍	❍	❍	❍	❍	
29.6: Indications for medications are included on written and electronic prescriptions. *(See FAQ 1 for futher explanation)*	❍	❍	❍	❍	❍	
29.7: A list of high-alert drugs (e.g., warfarin, low molecular weight heparin, oral methotrexate for nononcology use) is established from a list of drugs often prescribed in the practice that require direct contact of the physician and pharmacist for phoned-in prescriptions including renewals.	❍	❍	❍	❍	❍	
29.8: External medications (e.g., benzoin, podophylline) are labeled "For External Use Only" and are separated from internal-use medications in all storage areas.	❍	❍	❍	❍	❍	
29.9: All patients who are taking medications are asked at each office visit what medications they are currently taking and if they have had side effects, and their responses are documented in their medical record (e.g., "taking medications without problems" or record the nature and type of reaction or interaction).	❍	❍	❍	❍	❍	

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	A	No Activity
	B	Considered, but not implemented
	C	Partially implemented in some areas
	D	Fully implemented in some areas
	E	Fully implemented in all areas
	N/A	Item not applicable to our practice

	A	B	C	D	E
29.10: All practice staff who prescribe, dispense, administer and provide patient education on medications have easy access to current drug information and other decision support resources, and all drug information and clinical decision support resources used in the practice are standardized, maintained and updated at least yearly or whenever a new edition is available.	❍	❍	❍	❍	❍
29.11: All medications, reagents and other products that carry an expiration are routinely checked (at least quarterly) by a designated staff member and discarded once they have expired.	❍	❍	❍	❍	❍
29.12: All female patients of childbearing age are required to have a documented negative pregnancy test or other notation in the chart before medications are prescribed (including refill renewals) that are known to be teratogenic, and patient education regarding the need for effective birth control while taking these medications is provided.	❍	❍	❍	❍	❍
29.13: A manual or electronic system is in place to document all prescribed drug therapy and anticipated dates of prescription renewals**.**	❍	❍	❍	❍	❍

MEDICATIONS (Continued – items with N/A as an option)

	A	B	C	D	E	N/A
29.14: All multiple-dose vials of injectable medications used in the practice (e.g., lidocaine, dexamethasone, prochlorperazine, vitamin B12) are labeled with the date opened and include a date on which the unused product would be discarded no later than 30 days after opening. (Note: If the practice does not use or stock any injectable medications, even in emergencies, then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍
29.15: All medications dispensed to patients, including samples, are properly labeled with the name of the medication, strength, dose, frequency, lot number, expiration date and quantity of medication along with the patient's name, date dispensed and prescriber information, and are documented in the medical record. (Note: If the practice does not dispense any medications, including samples, then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍

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	No Activity
A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

	A	B	C	D	E	N/A
29.16: All vaccines dispensed or administered by the practice are documented in a log that contains the name of the vaccine, lot number, expiration date and the patient name, dose, and date administered or dispensed. (Note: If the practice does not dispense any vaccines, then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍
29.17: The practice purchases commercially prepared complex or compounded drugs or products or contracts with an outside source to provide these products. For example, the practice does not compound drugs or products. (Note: If the practice does not dispense any medications, including samples, then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍

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30. HANDOFFS AND TRANSITIONS

Patients often receive care from a number of different clinicians and facilities, and the physician and practice with principal responsibility for coordinating the patient's care endeavors to track the patient and the patient's clinical information across time and space. It is recognized that coordination and tracking these clinical events is not simple or easy, and that practices institute a variety of manual and computerized systems to accomplish them.

A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

	A	B	C	D	E
30.1: When the practice transfers responsibility for the care of a patient to another physician, practice, or institution, the practice identifies the clinician responsible for accepting the patient and confirms that the clinician receives and accepts responsibility for the patient. Necessary clinical information about the patient is transmitted to the accepting clinician; the practice determines that the information was received. It is documented in the patient's medical record that the patient has been transferred and that responsibility has been accepted by the receiving clinician, practice, or other institution. *(See FAQ 2 for further explanation)*	❍	❍	❍	❍	❍
30.2: When a patient is referred to an outside pathology laboratory, or a patient's specimen is sent to an outside pathology laboratory, the practice tracks the testing process, including when the patient is referred, when the specimen is sent, to what laboratory the patient or specimen is sent, the test(s) to be performed, when a report is expected, and which clinician(s) in the practice and outside the practice are to receive the report. The practice ensures and documents in the patient's medical record that the report has been received by the practice and has been delivered to the designated clinician(s), AND the clinician(s) is informed if a report has not been received by the expected date. The practice also has a mechanism to contact the pathology laboratory when reports are not received by the expected date.	❍	❍	❍	❍	❍
30.3: The practice maintains a process to communicate all medications (name, dose, frequency, route and purpose) that a patient is receiving when admitted to a hospital, nursing home, home care agency, rehabilitation center, etc. *(See FAQ 3 for further explanation)*	❍	❍	❍	❍	❍

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	A	B	C	D	E
30.4: When a patient is sent to another physician or practice for consultation, the practice tracks the consultation, including when the referral for consultation is made, to which consulting physician/practice, the purpose of the consultation, when a report is expected, and which clinician(s) in the practice and outside the practice are to receive the report. The practice ensures and documents in the patient's medical record that the consultation report is received by the practice and is delivered to the specified clinician(s), AND the practice informs the specified clinician(s) if a report has not been received by the expected time. The practice also has a mechanism to contact the consulting physician/practice when reports are not receivedby the expected date.	❍	❍	❍	❍	❍
30.5: A determination has been made as to which laboratory, pathology and imaging test results are to be considered "critical" and the practice has a mechanism that is distinct from the routine process for handling test results to determine when a critical test result is received and to immediately deliver that result to an appropriate clinician(s) and, when appropriate, to the patient. This mechanism for disseminating critical or emergent test results to clinicians and patients also functions outside normal business hours.	❍	❍	❍	❍	❍
30.6: The practice tracks when and to what imaging facility each patient is sent, the test(s) to be performed, when a report is expected, whether that report is received as expected, and which clinician(s) in the practice are to receive the report. The practice ensures that the imaging test report is received by the practice and is delivered to the specified clinician(s), AND informs the specified clinician(s) if a report has not been received by the expected time.The practice documents the results and their receipt in the patient's medical record. The practice also has a mechanism to contact the imaging facility when reports are not received by the expected date.	❍	❍	❍	❍	❍
30.7: The results of laboratory, pathology, and imaging tests are communicated to the patient in a timely manner (24 to 48 hours), and the practice confirms and documents that the patient received the results. Patients are notified of all laboratory, pathology, and imaging test results, including those that are "negative," whether or not they require further clinical action.	❍	❍	❍	❍	❍

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	A	B	C	D	E
30.8: The practice provides all patients with easy access to their consultative, laboratory, imaging, and other results and all patients are educated on how to obtain this information.	❍	❍	❍	❍	❍
30.9: The practice has identified emergent situations for which patients in the office are at immediate risk (e.g., chest pain/myocardial infarction, bowel obstruction, allergic reaction to medications administered in the office) that require the patient to be transferred quickly to another level of care. The practice has decided how to respond to each of these emergent situations should they occur in the practice. Clinicians in the practice periodically (at least once every 12 months) perform team review of what must be done in emergent situations.	❍	❍	❍	❍	❍
30.10: For a patient for whom the practice has continuing responsibility, the practice has a process to learn of essential new information about the patient from outside the practice (e.g., new prescriptions and significant changes in the patient's condition or plan of care) and to record them in the patient record. *(See FAQ 4 for further explanation)*	❍	❍	❍	❍	❍
30.11: When a patient for which the practice has responsibility is discharged from a hospital or other facility, the practice has a system that confirms the discharge information and enters it into the patient record.	❍	❍	❍	❍	❍

A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

31. SURGERY / ANESTHESIA & SEDATION / INVASIVE PROCEDURES

Many physician practices perform surgery and invasive procedures that were once limited to hospitals. These activities entail a variety of risks, including those associated with sedation and anesthesia.

A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

	A	B	C	D	E	N/A
31.1: The practice has identified and communicated to all clinicians surgical and other **invasive** procedures that could be performed onsite. (Note: If the practice does not perform any surgery or invasive procedures then answer this item with "NA".) *(See FAQ 5 for further explanation)*	○	○	○	○	○	○
31.2: For all surgical and other invasive procedures performed onsite, policies and procedures for patient selection, medications to be given, need for anesthesia support, and post procedure care are established and known by all staff. (Note: If the practice does not perform any surgery or invasive procedures then answer this item with "NA".)	○	○	○	○	○	○
31.3: The site of any surgical or invasive procedure to be performed for each patient is confirmed and documented by two staff members and the patient, before the procedure is begun. (Note: If the practice does not perform any surgery or invasive procedures then answer this item with "NA".) *(See FAQ 6 for further explanation)*	○	○	○	○	○	○
31.4: Conscious sedation is only administered when two qualified personnel are in attendance and one individual monitors the patient while the second individual performs the procedure. (Note: If the practice does not administer conscious sedation then answer this item with "NA".) *(See FAQ 7 for further explanation)*	○	○	○	○	○	○
31.5: The practice maintains a list of all clinicians who may perform surgical or invasive procedures that includes the procedures the clinician may perform. (Note: If the practice does not perform any surgery or invasive procedures then answer this item with "NA".)	○	○	○	○	○	○
31.6: The practice maintains and monitors a current list of clinical personnel authorized to administer and monitor anesthesia and sedation for all surgical and invasive procedures. (Note: If the practice does not perform any surgical procedures then answer this item with "NA".)	○	○	○	○	○	○

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32. PERSONNEL / QUALIFICATIONS / COMPETENCY

Practitioners and practice staff receive sufficient orientation to elements of safe care and undergo education and evaluation of skills to ensure consistent and appropriate application of those skills.

A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

	A	B	C	D	E
32.1: Employees are educated about new drugs or products by practice staff or other practitioners within the community before they are prescribed or used by the practice. For example, pharmaceutical and vendor sales representatives are not used as the sole source of new product education for office practice professional and nonprofessional staff.	❍	❍	❍	❍	❍
32.2: The practice maintains a system to provide continuing education to clinical and support personnel that is both specific and appropriate for the level of services provided in the practice. *(See FAQ 8 for further explanation)*	❍	❍	❍	❍	❍
32.3: The practice maintains a system to periodically (at least annually) assess nursing and support staff competency that is appropriate for the services and procedures they perform.	❍	❍	❍	❍	❍
32.4: The practice maintains a system to periodically (at least annually) assess physician competency that is appropriate for the services and procedures they perform.	❍	❍	❍	❍	❍
32.5: All new physicians, physician assistants and nurse practitioners receive a structured orientation to the practice's policies, procedures, administrative guidelines, etc.	❍	❍	❍	❍	❍
32.6: All new nursing and technical staff receive a structured orientation to the practice's policies, protocols, procedures, administrative guidelines, etc.	❍	❍	❍	❍	❍

PERSONNEL / QUALIFICATIONS / COMPETENCY (Continued– items with N/A as an option):

	A	B	C	D	E	N/A
32.7: Surgical procedures are provided by Board Eligible, Board Qualified, or Board Certified physicians trained in the appropriate subspecialty. (Note: If the practice does not perform any surgery or invasive procedures then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍
32.8: Surgical procedures are provided by licensed and/or certified non-physician medical staff trained in the specific procedure and who have current privileges to perform them in this setting. (Note: If the practice does not perform any surgery or invasive procedures then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍

	A	No Activity
	B	Considered, but not implemented
	C	Partially implemented in some areas
	D	Fully implemented in some areas
	E	Fully implemented in all areas
	N/A	Item not applicable to our practice

	A	B	C	D	E	N/A
32.9: Anesthesia is provided by Licensed Anesthesiologists or Nurse Anesthetists. (Note: If the practice does not perform any anesthesia then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍
32.10: The practice maintains separate policies, procedures, competency training, and continuing education programs for the treatment of pediatric patients. (Note: If the practice does not treat any pediatric patients then answer this item with "N/A".) *(See FAQ 9 for further explanation)*	❍	❍	❍	❍	❍	❍

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33. PRACTICE MANAGEMENT / CULTURE

In addition to the specific actions related to particular aspects of patient care such as medications or tracking diagnostic tests, there are also things the practice can do as a whole that support and complement the specific actions. Some of these help provide a "culture of safety" in the practice.

A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

	A	B	C	D	E
33.1: A system of reporting errors, such as incident reports, is in place and is supported by a culture of safety that allows for open collection and sharing of the data within the practice. *(See FAQ 10 for further explanation)*	❍	❍	❍	❍	❍
33.2: A protocol to report potential threats to patient safety and near-misses is in place, known to all staff, routinely followed and supported by a culture of safety that allows for open collection and sharing of the data within the practice. *(See FAQ 11 for further explanation)*	❍	❍	❍	❍	❍
33.3: When errors or near-misses occur, educational efforts are widespread among all clinicians and nonclinical personnel who may make a similar error, rather than remedial and directed only at those practitioners who were involved in the error, and education supports organizational learning and awareness and promotes system changes to decrease the possibility of future error.	❍	❍	❍	❍	❍
33.4: The published literature about errors and adverse events that have occurred in other locations is activity monitored and the practice uses the information to proactively make system changes within the practice. *(See FAQ 12 for further explanation)*	❍	❍	❍	❍	❍
33.5: Patients are instructed on the proper use and maintenance of any devices prescribed or dispensed to them by the practice. *(See FAQ 13 for further explanation)*	❍	❍	❍	❍	❍
33.6: When prescribing or dispensing oral liquid medications for patients, a proper measuring device (e.g., an *oral* syringe) is used or suggested and caregivers are instructed on its use to measure the prescribed dose.	❍	❍	❍	❍	❍
33.7: The practice has protocols in place that are known to all staff and are followed for providing emotional support to clinicians and other staff members that have been involved in an adverse event at the practice and encourages staff to utilize it. *(See FAQ 14 for further explanation)*	❍	❍	❍	❍	❍

	A	B	C	D	E
33.8: Job descriptions for all office personnel include requirements to speak up about safety issues, change practices to enhance safety, share errors, ask for help when needed, and other elements of shared accountability for safe practices.	❍	❍	❍	❍	❍
33.9: Job descriptions for all clinical personnel include requirements to speak up about safety issues, change practices to enhance safety, share errors, ask for help when needed, and other elements of shared accountability for safe practices.	❍	❍	❍	❍	❍
33.10: All office staff receives initial training on HIPAA regulations and periodic (at least annually) ongoing education, review and evaluation is offered.	❍	❍	❍	❍	❍
33.11: The practice documents all patient complaints and/or concerns about their care or outcomes including problems with communication between the patient and clinicians and staff within the practice and/or consulting or testing center staff. All complaints are periodically reviewed, shared with staff, and responses and resolutions are documented.	❍	❍	❍	❍	❍
33.12: The practice encourages patients by verbal or written surveys to share any safety concerns they may have while at the practice, with staff, or at outside referral centers.	❍	❍	❍	❍	❍
33.13: Human factors and the key principles of error reduction such as standardization, use of constraints and redundancy are reviewed with all office staff during orientation and during each performance evaluation. *(See FAQ 15 for further explanation)*	❍	❍	❍	❍	❍
33.14: Essential patient information is manually or electronically recorded on a separate intake form or record in such a way that it is clearly evident in the health record and easily accessible to appropriate office personnel.	❍	❍	❍	❍	❍
33.15: Patients are informed of HIPAA rules and regulations and how the practice protects patient data and other personal information and the specific circumstances where and to whom patient information can be released.	❍	❍	❍	❍	❍
33.16: The practice provides adequate space and a safe environment for treating patients to protect the patient from iatrogenic injury and infection.	❍	❍	❍	❍	❍
33.17: Staff feel comfortable requesting time away (schedule changes, breaks, increased requests for double checks or days off) due to illness and fatigue to minimize errors and the potential for compromise of safe care related to these conditions.	❍	❍	❍	❍	❍

	A	B	C	D	E
33.18: The practice utilizes established tools to monitor patient to staff ratio trends, flexible work schedules, sick-day use and burnout or low morale for impact of staff fatigue, overwork and understaffing on patient safety. *(See FAQ 16 for further explanation)*	❍	❍	❍	❍	❍
33.19: All practice staff are trained to recognize and manage health literacy issues. *(See FAQ 17 for further explanation)*	❍	❍	❍	❍	❍
33.20: The practice provides training to all staff in team communication including methods to ensure efficient and effective communication. *(See FAQ 18 for further explanation)*	❍	❍	❍	❍	❍

PRACTICE MANAGEMENT / CULTURE (Continued– items with N/A as an option):

	A	B	C	D	E	N/A
33.21: Procedures are established by the practice for maintenance, distribution and use of devices such as nebulizer units, glucose monitoring devices, intravenous infusion pumps or any other mechanical device used in the medication delivery process, and include standardization of the equipment, annual biomedical evaluation and cleaning. Responsibility for these procedures is assigned to one office staff member qualified to do the review. (Note: if the practice does not provide devices then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍
33.22: Office personnel, including physicians, are educated about all devices and associated protocols/guidelines; and competency with their use is verified before they are permitted to use or train a patient on the device. (Note: If the practice does not provide devices then answer this item with "N/A".)	❍	❍	❍	❍	❍	❍

34. PATIENT EDUCATION / COMMUNICATION

Patients' understanding of their illnesses and of recommendations for their care is particularly important in ambulatory care because the patient is largely responsible for following the care plan such as taking prescribed medications and getting needed tests. This section includes a number of actions that practices can take to help patients carry out their responsibilities.

A	No Activity
B	Considered, but not implemented
C	Partially implemented in some areas
D	Fully implemented in some areas
E	Fully implemented in all areas
N/A	Item not applicable to our practice

	A	B	C	D	E
34.1: Patients are assessed for their financial and physical ability to obtain prescriptions and medical supplies at the time of their office visit or when provided a prescription over the phone.	❍	❍	❍	❍	❍
34.2: The practice has identified patients with chronic diseases such as asthma, diabetes, hypertension and congestive heart failure within their patient population and provides special education and monitoring services such as follow-up calls for laboratory testing, consultations and prescription renewals for patients with these diseases.	❍	❍	❍	❍	❍
34.3: Information on patients' lifestyle, family, home environment and work is collected and used to develop a care plan when appropriate.	❍	❍	❍	❍	❍
34.4: Diagnostic and treatment care plans are communicated to patients and caregivers in an understandable manner and provided in a written format if required. For example, patients and/or caregivers are asked if they would like to receive a written care plan. A process is in place to communicate diagnostic and treatment care plans in a way that is understand by patients, and, when appropriate, their families.	❍	❍	❍	❍	❍
34.5: A medical provider in the practice explains to patients and, when appropriate, to families all risks from surgical procedures, anesthesia, diagnostic testing, etc. that are performed within the practice or performed at a referral center.	❍	❍	❍	❍	❍
34.6: Patients are routinely asked to repeat back what they hear to help the clinician clarify any instructions.	❍	❍	❍	❍	❍
34.7: For Limited English Proficiency (LEP) or hearing impaired patients, the practice provides qualified medical interpretation services or communicates through clinicians whose native language is appropriate or who have training in sign language. This includes adequately communicating the risks and benefits of treatment and procedures and patient understanding of these risks and benefits is evaluated and documented.	❍	❍	❍	❍	❍

	A	B	C	D	E
34.8: All patients receive the most critical information about a newly prescribed drug (e.g., specific instructions for use, serious interactions with other medications, important laboratory tests that must be performed) first in laymen terms, verbally AND in writing, before they leave the office.	❍	❍	❍	❍	❍
34.9: All patients and/or their caregivers are instructed to speak with their pharmacist and/or notify their prescriber of any questions they may have about their medications including the name, dose, frequency, route and shape or color of the medication.	❍	❍	❍	❍	❍
34.10: Patient participation is actively sought in decisions regarding their own care.	❍	❍	❍	❍	❍
34.11: The practice provides assistance to patients on how to obtain educational materials and resources such as brochures, books and Web pages on their conditions.	❍	❍	❍	❍	❍
34.12: A process is in place to insure timely follow-up of e-mail and telephone correspondence with patients and other health care providers.	❍	❍	❍	❍	❍
34.13: All patients receiving critical information by phone about a newly prescribed drug, treatment, diagnostic test or laboratory result are asked to repeat back the information and any instructions before the call is terminated.	❍	❍	❍	❍	❍

END OF ASSESSMENT

Frequently Asked Questions (FAQs)

General FAQs

What are the benefits of completing the assessment and submitting data to the PPPSA project?
For practices that complete the self assessment and submit their results, the project will be of significant assistance to physicians, medical practice administrators and practice staff who seek to identify areas of potential patient risk in their organization, so that leadership support can be sought for improvements in these critical areas.

The project will provide MGMA, ISMP, HRET, and others with the ability to identify common areas of risk in medical practices and offer practical system improvements, including those that are thought to provide the highest leverage for overall risk reduction and improvement in patient safety.

The collection and aggregate analysis of data from a national sample of physician practices will also enable the medical practice community to:

- Understand the current status of patient safety and the systems that practices have in place to manage patients' care safely. Analysis of these data will be useful in advising medical practices about areas for potential improvement of patient safety, and will provide a baseline for measuring improvement over time.

- Equally important, the PPPSA project will also collect and distribute to physician practices examples of improvements that practices are making to increase safety and reduce risk so that others can learn from these examples. The PPPSA project will find and distribute tools and methods that practices can use to improve the processes and systems that are used to manage medications, information, and other key aspects of care.

It will be important for practices to examine their self assessment results and to consider improvements in particular areas. Comparing the practice's results to the aggregate results may help identify those areas.

A practice that performs a self assessment and submits data to the PPPSA project is likely to find areas that need improvement. Will this put the practice at greater risk for malpractice liability in the future?

It is likely that every practice that does a self assessment will find some areas that need improvement. Many of the items in the self assessment represent ideal or state-of-the-art practices, processes, and systems that will be a "stretch" for most practices. Doing the self assessment will enable practices to get a head start in improving safety and reducing risk of harm adverse events and future potential malpractice liability. Also, each practice's self assessment results are submitted confidentially to the PPPSA database, and the data will be analyzed only in the aggregate, with benefit to all practices that participate in the project.

We are a highly specialized medical practice (e.g., orthopedic surgery or gastroenterology). Is the PPPSA assessment valid for our practice?
The self assessment has many items that will apply to essentially all medical practices regardless of size and specialty type. However, some items are more likely to be applicable to a primary care practice (e.g., managing consults from specialists) but others will be particularly applicable to a surgical practice (e.g., the use of anesthesia). To accommodate differences among practices, some of the self assessment items allow a "Not applicable" response. In addition, the PPPSA project team welcomes feedback from practices about new items that could be added to the assessment or how items could be improved, including modifications that would make items more useful to highly specialized practices. If you have suggestions, please contact us at pmr@mgma.com.

Assessment Question FAQs

FAQ 1 (for Question 29.6)

Indications for medications are included on written and electronic prescriptions.

Why should indications be included on prescriptions and how should that be done?

Studies have shown that 25% of medication errors are a result of drug names that look-alike or sound-alike. Many look-a-like and sound-a-like medications are used for different indications. By including the indication on the prescription, dispensing errors can be avoided. Indications can be written on the prescription (e.g. Zyrtec, 10 mg, one tablet once a day for allergies), selected from a pick list, or included in the comment field with electronic systems, or by using prescriptions that include icons (e.g. pictures of lungs, heart, kidneys).

FAQ 2 (for Question 30.1)

When the practice transfers responsibility for the care of a patient to another physician, practice, or institution, the practice identifies the clinician responsible for accepting the patient and confirms that the clinician receives and accepts responsibility for the patient. Necessary clinical information about the patient is transmitted to the accepting clinician; the practice determines that the information was received. It is documented in the patient's medical record that the patient has been transferred and that responsibility has been accepted by the receiving clinician, practice, or other institution.

What is "necessary clinical information"?

The necessary or essential clinical information that should be transmitted with the patient will vary. One example or suggested version is provided by the Continuity of Care (CCR) project, which was developed to organize and make transportable a set of basic information about a patient's health care that is accessible to clinicians and patients. The CCR set is designed to have information on transferring and receiving clinicians and key information about the patient's diagnoses, problems, and condition, known allergies, medications, recent history including vital signs and laboratory test results, some information about planned treatment or testing, and basic insurance information. More information about the CCR can be found on the web site of the Medical Records Institute http://www.medrecinst.com/pages/about.asp?id=54 and the American Academy of Family Physicians website http://www.centerforhit.org/x201.xml.

FAQ 3 (for Question 30.3)

The practice maintains a process to communicate all medications (name, dose, frequency, route and purpose) that a patient is receiving when the patient is admitted or referred to a hospital, nursing home, home care agency, rehabilitation center, etc.

What is meant by "process" in this question?

Each practice should provide or review a current list of medications including name, dose, route, frequency, and indication with patients at each practice visit. Patients and/or their caregivers should be instructed to share this list with health professionals when they are seen at a hospital or admitted to a nursing home or other short term or long term facility. The practice should maintain a current copy of this list and provide it to other healthcare professionals who may be treating or caring for the patient.

FAQ 4 (for Question 30.10)

For a patient for whom the practice has continuing responsibility, the practice has a process to learn of essential new information about the patient from outside the practice (e.g., new prescriptions and significant changes in the patient's condition or plan of care) and to record them in the patient record.

What are ways the practice can learn about information on patients?

When a patient for whom a practice will assume continuing responsibility is discharged from a hospital or other facility, the discharge summary or similar information (such as that in the continuity of care record) should be provided by the discharging facility to the practice and to the responsible clinician. The practice may choose to establish a mechanism to anticipate such discharges and to ensure that this information is received from the discharging facility, in the same way that the practice will need to establish mechanisms to determine that it receives the results of outside laboratory and pathology tests and consultations.

FAQ 5 (for Question 31.1)

*The practice has identified and communicated to all clinicians surgical and other **invasive** procedures that could be performed onsite. (Note: If the practice does not perform any surgery or invasive procedures then answer this question with "NA").*

What is the difference between surgery and invasive procedures? How are surgery and invasive procedures defined?

For the purposes of this question there is no difference between surgical and other invasive procedures in the office setting. All would require a determination by the practice of the ability to perform them onsite. Surgical or other invasive procedures are defined as those involving a skin incision or puncture including and excluding venipuncture or the placement intravenous catheters. In addition other specific examples of invasive procedures include but are not limited to:

- Biopsy
- Skin or wound debridement performed in an office setting
- Electrocautery of skin lesion
- Endoscopy
- Laparoscopy
- Injections into a joint space or body cavity
- Percutaneous aspiration of body fluids
- Central vascular access device insertion
- Laser therapy
- Dermatology Procedures
- Invasive ophthalmic procedures, including miscellaneous procedures involving implants
- Oral surgical procedures including tooth extraction and gingival biopsy

FAQ 6 (for Question 31.3)

The site of any surgical or invasive procedure to be performed for each patient is confirmed and documented by two staff members and the patient, before the procedure is begun. (Note: If the practice does not perform any surgical or invasive procedures, even in emergencies, then answer with "NA")

What is the process for confirming the surgical site by the operative team?

Prior to beginning any surgical or invasive procedure, the operator and any assistants pause to check the identity of the patient, review the planned procedure and confirm that the operative site is the one that was planned by the operator and the patient. This formal "time out" is the final safety check prior to proceeding with the surgical or invasive procedure.

FAQ 7 (for Question 31.4)

Conscious sedation is only administered when two qualified personnel are in attendance and one individual monitors the patient while the second individual performs the procedure. (Note: If the practice does not administer conscious sedation, even in emergencies, then answer this question with "NA".)

How are qualified individuals defined? What are the characteristics of conscious sedation and how does it differ from other types of anesthesia?

Conscious sedation is a form of anesthesia that induces a minimally depressed level of consciousness. It allows the patient to maintain a patent airway independently and continuously and respond appropriately to physical stimulation and verbal commands. It differs from deep sedation and general anesthesia only in the level of consciousness maintained. All anesthesia requires close monitoring of vital signs, physiologic functioning, and the appropriate level of consciousness.

Qualified personnel are those licensed practitioners who by education, training, and experience are privileged to deliver and monitor conscious sedation in the practice setting. In addition, it is important that each individual also have training to rescue the patient from deep sedation and that the practice confirm that ability through ACLS certification, written examination scores or process review proctored by an anesthesiologist.

FAQ 8 (for Question 32.2)

The practice maintains a system to provide continuing education to clinical and support personnel that is both specific and appropriate for the level of services provided in the practice.

How should continuing education be provided?

Continuing education may be provided internally by qualified staff in the practice or by staff attending programs provided outside the practice.

FAQ 9 (for Question 32.10)

The practice maintains separate policies, procedures, competency training, and continuing education programs for the treatment of pediatric patients. (Note: If the practice does not treat pediatric patients, even in emergencies, than answer this question with "NA".)

Why is it important to have separate policies and procedures for the care of children?

Since children are not just small adults and have unique medical needs and requirements, which may not be appreciated by practitioners who care for an adult population, the practice should place special emphasis on their care. This emphasis should take the form of assessing the competency of the individual practitioner and support staff to care for children, assuring that resources relating to the care of children are available to all the staff, and that continuing education about pediatric care is offered in order to support the unique skills in pediatric care.

FAQ 10 (for Question 33.1)

A system of reporting errors (e.g. incident reports) is in place and is supported by a culture of safety that allows for open collection and sharing of the data within the practice.

Why is this important and what are ways to accomplish this?

A formal method for recording errors, such as incident reports, whether online or paper, provides a practice with the opportunity to document what happened, analyze the causes of the incident (e.g. root cause analysis when appropriate) and amend their process as needed to minimize opportunity for a similar failure occurring. In addition, regular and in-depth multidisciplinary review of these reports should take place to identify patterns and trends that could indicate larger systems issues that are at play, launch failure mode and effects analysis (FMEA) work within the practice and to facilitate the development of communications to provide experiential education to the practice staff.

FAQ 11 (for Question 33.2)

A protocol to report <u>potential threats</u> to patient safety and <u>near-misses</u> is in place, is known to all staff, routinely followed and supported by a culture of safety that allows for open collection and sharing of the data within the practice.

What is the value in recording incident and mistakes where a patient isn't harmed?

Learning by uncovering possible error prior to harm occurring presents an effective opportunity for improvement by the practice. Examples of informal methods of recording "near misses" include glitch books, near miss reports, suggestion boxes, and narrative storytelling at staff meetings and brown bag lunches. It is also suggested that an organization have set a routine time to meet to share and analyze external and internal errors instead of waiting to meet and discuss errors only when something goes wrong (see FAQ for reporting).

FAQ 12 (for Question 33.4)

The published literature about errors and adverse events that have occurred in other locations is actively monitored, and the practice uses the information to proactively make system changes within the practice.

What are some effective tools to keep abreast of the literature?

Methods for monitoring include storing searches using the National Library of Medicine's PubMed database and the "My NCBI" service (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi) to receive regular periodic alerts on defined subjects of interest, working with a medical librarian to generate individual bibliographies, or subscribing to newsletters, periodicals, listserv or web sites that provide literature announcements (e.g., the Agency for Healthcare Research and Quality's Patient Safety Net [PSNet] site at http://psnet.ahrq.gov/).

FAQ 13 (for Question 33.5)

Patients are instructed on the proper use and maintenance of any devices prescribed or dispensed by the practice.

What types of devices or procedures require additional instructions to patients upon discharge from the practice setting?

Anytime a patient is discharged from a practice setting and is required to use a device to administer medicines, support a physiologic function or to provide ongoing treatment, the patient should be fully educated in the use of the device, its potential for failure and the proper maintenance to keep it optimally operational. In most circumstances, this responsibility for self care can be best accomplished by observing the patient use the device prior to discharge and when appropriate observe the patient perform routine maintenance and dispose of the device properly.

FAQ 14 (for Question 33.7)

The practice has protocols in place that are known to all staff and are followed for providing emotional support to clinicians and other staff members that have been involved in an adverse event at the practice and encourages staff to utilize it.

What are ways to provide this support to staff?

Practice should have established a relationship with an employee assistance program or other credible support resource that is skilled in responding to error support (e.g. Medically Induced Trauma Support Services (MITSS) in Massachusetts). Other processes for support could include trained mentors or preceptors that are available to both the general staff and individuals directly involved in the incident.

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FAQ 15 (for Question 33.13)

Human factors and the key principles of error reduction such as standardization, use of constraints and redundancy are reviewed with all office staff during orientation and during each performance evaluation.

What is meant by "human factors"?

Human factors (or human factors engineering) refers to the study of human abilities and characteristics as they affect the design and smooth operation of equipment, systems, and jobs. For instance, human factors analysis led to the now generally accepted recommendation that hospitals standardize equipment such as ventilators, programmable IV pumps, and defibrillators (ie, that each hospital pick a single type, so that different floors do not have different defibrillators) and more generally the principle that equipment be standardized within a system wherever possible. This principle is also being applied within physician practices. (PSNET glossary. Agency for Healthcare Research and Quality. Available at: http://psnet.ahrq.gov/glossary.aspx.)

FAQ 16 (for Question 33.18)

The practice utilizes established tools to monitor patient to staff ratio trends, flexible work schedules, sick day use and burnout or low morale for impact of staff fatigue, overwork and understaffing on patient safety.

How should a practice monitor staffing concerns that can impact patient safety?

A variety of tools exist that have been tested to gather data assessing culture and how it contributes to safety. In fact, this assessment may be used as a benchmarking tool for practices that seek to track improvements and changes in their safety work over time. In addition, establishing an executive rounding program will allow for staff to share their concerns with management directly.

FAQ 17 (for Question 33.19)

All practice staff are trained to recognize and manage health literacy issues.

How can practice staff access patient literacy?

Patients that have trouble reading and understanding health information can be difficult to identify. Behaviors to watch for that could indicate a literacy deficiency include: reluctance to read materials at the practice, inability to complete forms and lack of ability to name medications or explain their purpose. (Citation: Weiss BD, ed. Health Literacy: A Manual for Clinicians. Chicago; American Medical Association: 2003. Available at: http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf)

FAQ 18 (for Question 33.20)

The practice provides training to all staff in team communication including methods to ensure efficient and effective communication.

What are examples of effective communication and tools that support it?

Ineffective communication between caregivers has been indicated as a contributor to error in the hospital setting. Methods such as readbacks, walk rounds, process checklists, and morning briefings have all been utilized to increase the reliability of improving the information exchange between members of the care team.