PATIENT SAFETY DURING SYSTEM EXPANSION

DISCUSSION GUIDE FOR CLINICAL LEADERS: ALL-SPECIALTY

INSTRUCTIONS

Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety. **If you can only work through a short list of topics, start with the high-priority questions in bold text**. They can be used to explore areas of difference that can significantly impact patient safety.

EMERGENCY SITUATIONS

Describe how you call and run a code at your institution.

How are physicians oriented to institution-specific emergency resources?

How and when are crisis checklists used?

How is your hospital's massive transfusion protocol activated for obstetric and non-obstetric hemorrhage?

Describe your institution's disaster plan and related staff training.

ROLES AND RESPONSIBILITIES

What services are not available on nights and weekends?

How do you transfer a patient to the ICU?

How many shifts must physicians (including those "visiting" from other institutions) complete on a regular basis to maintain proficiency with current and new institutional practices?

Describe the orientation you provide for physicians new to your organization.

Describe the ways in which you resolve disagreements between professional staff about medical management.

How do you define the scope of practice for Advanced Practice Clinicians (APCs) and what are your rules for physician supervision of APCs? Examples:

- prescribing (controlled substances)
- presence at certain procedures (extubation, minor surgery)

What is your system for ensuring that Residents and Attendings have a common understanding of Resident responsibilities and supervision?

INFRASTRUCTURE AND RESOURCES

What is your protocol for identifying and transferring patients into or out of a unit when their clinical complexity no longer matches the unit's ability to care for them? *(Describe what is included for both intra- and inter-hospital transfers.)*

Describe your ICU(s).

- **Open unit or closed?**
- **Intensivist-led?**
- **Who is in in-house during nights and weekends?**
- **What type of coverage does the intensivist provide on nights and weekends?**
- **What can be accomplished in the ICU overnight and during weekends (e.g., line placement, dialysis initiation)?**

Describe your computerized physician order entry (CPOE).

Describe your electronic medical record (EMR) and identity components within the EMR that are not interoperable.

Describe how one accesses past medical history of patients.

What is the system for reconciling medications at your institution?

Do you have a policy for nurse staffing based on staff-to-patient ratios, and what are your target ratios?

Describe your system for assessing and documenting nursing staff competence.

What decision support tools can physicians access? (e.g., Up to Date, Isabel)

During what hours is a clinical pharmacist available?

What are your expectations for the availability and response time of consultants?

What are your expectations for how consultants communicate with other physicians and patients?

Describe your use of telemedicine services.

What resources are available for the care of infants and children?

What is the discharge process for patients?

- How do you confirm that patients have understood discharge instructions?
- How does the responsible outpatient physician receive handoff information following discharge?
- In what ways do you touch base with patients after they leave the hospital? (e.g., to check on them or to ensure appropriate outpatient follow-up?)

What is your process for integrating new technologies (e.g., robotics, laser) and how do you train physicians and nurses on those new technologies?

PATIENT SAFETY AND QUALITY IMPROVEMENT

Describe your process for incorporating new guidelines into your practice standards.

Describe how each department collects, aggregates, and trends complication rates.

- **Does each department determine what to track?**
- **How do you ensure that all departments collect and report information in a similar way?**

Describe your policy and procedure for handoffs when the responsible clinician changes.

Describe how your institution does mock drills. Consider:

- **format (e.g., team briefings vs. huddles)**
- **frequency**
- **content**
- **participants**

How can we work together to improve patient safety? To improve quality of care?

What are your surveillance systems for actively measuring misdiagnoses, delays in care, and inappropriate therapies?

What are the follow-up systems for abnormal labs and radiology?

Describe the system used by your hospital to identify when consults and referrals have not been completed in a timely way, and describe how the requester is notified.

Describe your system for closed loop communication of patient laboratory and radiology results (including after discharge).

Describe your policy and procedure for disclosing adverse events and outcomes to patients.

How do you assess patient experience and family engagement in care?

- What is your system for addressing negative patient and/or family experiences?

Describe your electronic capture system for reporting safety events.

Describe how your institution makes quality measures easily comparable across departments.

Describe your protocols for improving the perioperative safety of high-risk patient populations. Examples:

- obese patients
- elderly patients
- frail patients

Describe your hospital's Patient Safety and Quality Improvement (PSQI) Committee.

- How often do they meet?
- What are your hospital's main PSQI goals?
- What are the two most recent changes that the hospital enacted as a result of the PSQI Committee's work?

CULTURE

How are quality metrics (such as survival rates, infection rates, and patient satisfaction) made visible to institutional leaders and to frontline staff?

What factors influence the appointment of department chairs?

What are the biggest drivers of patient care decisions at your institution?

What barriers (if any) do you experience as you try to accomplish your work?

QUANTITATIVE PATIENT SAFETY PARAMETERS

How often does your hospital board discuss patient safety and quality improvement issues?

Is your CEO aware of infection rates?

How many root-cause analyses occurred at your hospital last year?

When was the last time your hospital reported a serious event to the Department of Public Health and what was it?

What is the percentage, overall and for each relevant department, of "Yes" responses to the HCAHPS survey question:

» "Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?"

What is the percentage, overall and for each relevant department, of "Agree" and "Strongly Agree" responses to the HCAHPS survey question:

» "When I left the hospital, I clearly understood the purpose for taking each of my medications."

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PATIENT SAFETY DURING SYSTEM EXPANSION

DISCUSSION GUIDE FOR CLINICAL LEADERS: OBSTETRICS SUPPLEMENT

This guide presents a list of obstetrics-specific considerations that affiliating organizations should jointly consider, with a goal of increasing the value of care for their joint patient population.

INSTRUCTIONS

Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety.

EMERGENCY SITUATIONS

Describe your system for maternal resuscitation, including a designated response team from anesthesia, pediatrics, and a surgical airway manager, and describe which personnel are available by time of day and day of week.

Describe your use of a checklist for management of obstetric hemorrhage and hypertensive crisis.

ROLES AND RESPONSIBILITIES

What are the unique and overlapping roles of physicians and CNMs?

INFRASTRUCTURE AND RESOURCES

Describe your protocol for the use of oxytocin. Examples:

- indications
- initial and incremental doses and intervals
- dose reductions/stopping

Describe your policy and procedure for scheduling early elective delivery.

What is included in your guidelines for circumcision? Examples:

- contraindications
- elements of consent
- surgical pause
- pain relief
- qualifications of performing clinicians

What is included in your protocol for identification and transfer of patients into or out of a unit when their clinical complexity no longer matches the unit's ability to care for them?

PATIENT SAFETY AND QUALITY IMPROVEMENT

What is included in your guideline for care of pregnant women after prior cesarean? Examples:

- » elements of counseling
- » antepartum diagnosis of abnormal placentation
- » intra-operative contingency planning
- » backup for VBAC

Describe your perinatal QI committee.

- » Does it include representatives from pediatrics, anesthesia, nursing, and midwifery?
- » How often do they meet?
- » How do they review trended quality data and individual cases?
- » How do they oversee improvement work?

Does your organization use a pre-procedure safety checklist before all obstetric procedures?

- » What does your checklist include?

Describe your team trainings for OB emergencies. Consider:

- » Who is included?
- » How frequently do they occur?
- » What topics have been covered in the last 2 years?

QUANTITATIVE PATIENT SAFETY PARAMETERS

What are the ratios of delivering patients per OR and per L&D room last year?

What was the nulliparous term singleton vertex (NTSV) cesarean rate last year?

How many obstetric morbidity and mortality conferences occurred last year?

How often is each provider's competency in EFM interpretation assessed?

PATIENT SAFETY DURING SYSTEM EXPANSION

DISCUSSION GUIDE FOR CLINICAL LEADERS: EMERGENCY MEDICINE SUPPLEMENT

This guide presents a list of emergency medicine-specific considerations that affiliating organizations should jointly consider, with a goal of increasing the value of care for their joint patient population.

INSTRUCTIONS

Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety.

EMERGENCY SITUATIONS

How does your existing equipment for managing pediatric emergencies compare with the 2010 AAP/ACEP/ANA guidelines?

ROLES AND RESPONSIBILITIES

Which physician decides whether a patient in the Emergency Department (ED) will be admitted and to what service?

What are the criteria for staffing the ED (e.g., Board Certification status of physicians) and what are the physicians' designated responsibilities? Examples:

- ability to admit
- involvement in patient work-up

Describe the orientation for all new providers in the ED.

Describe your OPPE/FPPE processes.

Describe how you manage critical conditions. Examples:

- STEMI
- aortic dissection
- spinal cord injury
- sepsis
- airway emergency
- pediatric emergency

INFRASTRUCTURE AND RESOURCES

What are your Emergency Department (ED)'s internal resources to manage codes involving:

- » intubation
- » septic shock
- » complex intubation
- » critically ill patient
- » surgical airway
- » cardiopulmonary resuscitation

Describe how the capabilities of inpatient units and on-call staff are reflected in your criteria for:

- » hospital admission
- » transfer out of the ED for specific conditions

Describe your mechanism for scheduling outpatient follow-up prior to a patient's departure from ED.

How many shifts per month are staffed with nurses trained in Pediatric Advanced Life Support or Advanced Pediatric Life Support?

PATIENT SAFETY AND QUALITY IMPROVEMENT

Describe your Emergency Medicine QI committee.

- » Which services participate?
- » Which professionals (e.g., physicians, nurses, etc.) participate?
- » How often do they meet?
- » How do they review trended quality data?
- » How do they oversee improvement work?

Describe your physician peer-review process. Examples:

- » participants
- » regular meetings
- » standardized evaluation criteria
- » tracking of results
- » feedback of all evaluations to providers

QUANTITATIVE PATIENT SAFETY PARAMETERS

What percentage of ED physicians are board certified/eligible or highly experienced in emergency medicine?

What are the patient-to-staff ratios (actuals, not targets) for nurses on each shift?

How many patients per hour do you expect physicians and APCs to see on each shift?

What was your staff turnover rate (all non-physicians) last year?

What is the average response time to a page for a consult to the ED?

What proportion of patients return to the ED within 72 hours of discharge?

How many times were peer-protected, multidisciplinary case review conferences held last year?

How many "Never Events" did you have in the last 12 months?

Percentage of arrivals who left without being seen last year.

Percentage "Good" or "Excellent" on patient survey question:

- "Likelihood of your recommending our Emergency Department to others"

What proportion of patients are children? (Both under 16 years and under 2 years)

PATIENT SAFETY DURING SYSTEM EXPANSION

DISCUSSION GUIDE FOR CLINICAL LEADERS: SURGERY SUPPLEMENT

This guide presents a list of surgery-specific considerations that affiliating organizations should jointly consider, with a goal of increasing the value of care for their joint patient population.

INSTRUCTIONS

Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety.

EMERGENCY SITUATIONS

How does one get help for airway emergencies during nights and weekends?

Describe the on-call availability of vascular surgeons and thoracic surgeons (include variation on nights, weekends, and holidays).

Describe your protocol for identifying and transferring patients whose clinical complexity exceeds the unit's ability to care for them on the floor.

Are there cases and conditions for which this hospital's anesthesia department is not comfortable or equipped to provide care?

ROLES AND RESPONSIBILITIES

What do you do to foster a team approach in the OR?

INFRASTRUCTURE AND RESOURCES

What roles do physicians play in your pre-admission testing center? Consider:

- Who sets standards?
- How are services/consults accessed?
- What is measured?

What criteria do you use for establishing operating privileges (which operations a surgeon may schedule)?

What are the guidelines for surgical and medical staff coverage on nights and weekends?

What is the availability of critical consulting services (cardiology, renal, and infectious diseases) at night and on weekends?

What is the policy for doing cases in the operating room overnight and/or on weekends?

Explain how the pre-operative process assures that there is sufficient information and time to make certain that a patient undergoing an elective surgery is optimized for that surgery.

PATIENT SAFETY AND QUALITY IMPROVEMENT

Describe your system for tracking operative complication rates in each department.

What is your policy on concurrent surgery?

What is your policy on procedural volume standards?

QUANTITATIVE PATIENT SAFETY PARAMETERS

How many morbidity and mortality conferences occurred last year?

PATIENT SAFETY DURING SYSTEM EXPANSION

DISCUSSION GUIDE FOR CLINICAL LEADERS: ONCOLOGY SUPPLEMENT

This guide presents a list of Adult Medical Oncology-specific considerations (focused on chemotherapy) that affiliating organizations should jointly consider, with a goal of increasing the value of care for their joint patient population.

INSTRUCTIONS

Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety. **If you can only work through a short list of topics, start with the high-priority questions in bold text.** They can be used to explore areas of difference that can significantly impact patient safety.

CONTEXT

Why is Oncology different from other specialties in this guide?

- Practice is largely ambulatory
- Merger of small practices with larger centers often results in hub and spoke care model
- Frequent need to tightly coordinate care closely with other specialists, especially radiation oncologists and surgeons
- High-quality communication across disciplines (nursing, advance practice providers, physicians, pharmacists) essential to provide safe care
- Well accepted standards for safe chemotherapy administration (ASCO/ONS)
- Use of drugs with very tight therapeutic/toxic ratio requires close follow up
- Frequent approval of new agents and new classes of chemotherapy drugs, often with new and unique toxicity profiles, requires providers to regularly update their knowledge
- Growing use of oral chemotherapy drugs transferring responsibility of administration from the cancer center to the patient
- Prompt recognition and management of treatment side effects are essential to avoid life-threatening consequences
- Many patients require long-term opioid use
- Psychosocial needs of patients and families often intense – benefit from support services including palliative care, social work, nutrition, others
- Very high cost of anti-cancer drugs and supportive medications can lead to significant financial stress for patients

LEADERSHIP AND CULTURE

What are the goals and values of both institutions and how do they align?

Describe how leadership is structured at your oncology practice.

- What does the hierarchy look like? How does leadership interact with frontline health workers?
- What are the professional backgrounds of those in leadership?

What does the leadership team value?

- In what ways, if at all, do those values affect how care is provided at your oncology practice?

What are some practices that are typical of the leadership team?

- In what ways, if at all, do those practices affect how care is provided at your oncology practice?

How do people work together at your oncology practice?

- How are they supported by leadership?

Financial constraints are a reality that most practices face. How has leadership balanced financial constraints with safety culture at your oncology practice?

- What has worked well?
- What hasn't worked well?

What is the nature of the affiliation?

- What do you foresee as being the positives of the affiliation?
- What are you most concerned about regarding the affiliation?

Generally, how is change managed at this oncology practice? i.e.,

- Changes in leadership?
- Changes in patient patterns?

NOTE: *If you are unable to answer these questions and/or they raise any concerns from either affiliating party, please consider jointly reviewing our Joint Clinical Integration Guide. It contains best practices on how to prioritize and manage clinical safety in the setting of system expansion.*

ROLES AND RESPONSIBILITIES

How does your oncology practice ensure that staff members who prepare chemotherapy have appropriate training? How is it documented?

How does your oncology practice ensure that staff members who administer chemotherapy have appropriate training? How is it documented?

Regarding ordering of chemotherapy:

- What certifications are required to be able to order chemotherapy? Probe: Must physicians be oncology specialty-trained AND board certified? How does your practice ensure that providers who are ordering chemotherapy have appropriate certifications?
- What, if any, exceptions are there to this policy?
- What privileges, if any, do advanced practice providers have for ordering chemotherapy? What about for ordering oral agents?

In regards to chemotherapy preparation and handling:

- Who does the preparation of chemotherapy? What is their training?
- What competency assessment is utilized (e.g. USP 800 exposure to hazardous drug education, aseptic technique, other regulatory requirements)?
- How are chemotherapy spills handled? How are people trained to handle them?

What do your work teams look like? Specifically, at your oncology practice, how do your physicians work with:

- nurse practitioners?
- physician assistants?
- pharmacists?
- nutritionists?
- trainees/fellows?
- palliative care?
- social workers?

How do you partner with Pathology to ensure timely and accurate diagnoses?

How do you partner with Radiology to ensure timely and accurate diagnoses?

How does your oncology practice discuss diagnoses and treatment plans with the care team? Do you have tumor boards? If so, how often, who participates, and what is the structure/content?

What are the criteria for deciding when a case requires additional Pathology review?

- Outside review (e.g. a second opinion from a pathologist at another hospital)?
- Internal review (e.g. a “double read” within the same department)?
- What processes are available if a physician is concerned about a report and would like an additional review (external or internal)?

When team members (physicians, pharmacists, and/or NPs) are employed by different entities, what is the nature of their access to clinical support tools?

INFRASTRUCTURE AND RESOURCES

How does your practice enter orders to prescribe IV chemotherapy?

How do you know which order set to use (if applicable) for a particular patient?

How does your oncology electronic health record (EHR) work?

- » Is it free-standing? Is it part of a larger health system?
- » Is there a linkage between prescribed inpatient chemotherapy orders and the outpatient EHR?
- » Is there a linkage between prescribed outpatient chemotherapy orders and the inpatient EHR?

Are there technology alerts built into the EHR to prevent the following:

- » Inappropriate routes of chemotherapy administration?
- » Excessive or subtherapeutic chemotherapy doses (using protocol-specific dosing ranges)?

How does the practice approach opportunities for care standardization? For example:

- » Has the practice created standard chemotherapy order sets?
- » Do they include standardized supportive care medications (anti-emetics, growth factors, etc.)?
- » On what references were they based?
- » If there are written order sets, how are these kept updated and tracked?
- » Do order sets include standard criteria for dose adjustment based on tolerability and/or toxicity?
- » Does the practice utilize clinical pathways? If so, what percentage of treatments are on-pathway?
- » How are patients monitored when their chemotherapy plan is outside of the generally established guidelines?

What inpatient oncology-specific resources are available for your patients? (For example: resources for obtaining chemotherapy as an inpatient)

What is your consent process like prior to starting chemotherapy?

- » Is it oral or written?
- » Does consent apply to all anti-cancer therapy (i.e. including oral chemotherapy)?
- » Is there crossover between inpatient and outpatient consents?

What are the practices for off-hours? (i.e. what resources are / are not available during off hours)?

- » What are the practices for weekend coverage?
- » What are the practices for night coverage?

Does your chemotherapy infusion room support non-cancer patients (i.e. benign hematological disease, rheumatoid arthritis)?

- » If so, how is this coordinated with cancer patients?
- » If so, how is this coordinated with non-oncologists?

In regards to oral chemotherapy:

- How are oral agents ordered?
- How are oral agents prepared?
- How are oral agents dispensed?
- How are they tracked? (i.e. tracked in the EHR)
- How do you assure adherence with oral medications? How do you monitor oral medication usage?
- How do you ensure that prescriptions are filled?

What are your policies for the following aspects of chemotherapy?

- Drug preparation?
- Drug administration?
- Product labeling?
- Drug dispensing? (Specifically, does any chemotherapy require preparation or manipulation in the treatment area by the practitioner who will be administering it?)

What laboratory checks are required prior to starting chemotherapy? (e.g pregnancy test and/or tests specific to current treatment)

When during the workflow are lab tests evaluated?

- Are they evaluated prior to preparation of the first dose of chemotherapy?
- Prior to administration of the first dose of chemotherapy?
- Before subsequent doses are indicated?
- Who is responsible for reviewing them if the patient is not seeing the doctor that day?

Is there a system in place to document/track/communicate the lifetime cumulative dose of chemotherapy as appropriate?

- Could you describe the system? How does it work?

Who is ultimately responsible for addressing cumulative dose issues?

Is there a system in place to coordinate the collection of documentation regarding advance directives or decision-making delegation?

- Could you describe the system? How does it work?

How are physicians and other healthcare providers made aware of critical results? For example:

- How does a physician confirm receipt of priority results?
- Does the practice have electronic access to testing performed in outside facilities?

Please describe a pre-procedure assessment at your oncology practice.

How do you ensure that the patient's condition is optimal prior to starting chemotherapy?

Before the first administration of a new chemotherapy regimen, does your chart documentation include the following:

- pathologic confirmation of initial diagnosis?
- initial cancer stage?
- current cancer status?
- chemotherapy treatment plan? If so, what does the chemotherapy treatment plan include? (i.e. Patient diagnosis? Drugs? Doses? Duration of treatment? Goals of therapy? Anything additional?)

Does your oncology practice participate in clinical trials? If so, please describe for:

- phase I?
- phase II?
- phase III?

PATIENT SAFETY AND QUALITY IMPROVEMENT

Is your oncology practice Commission on Cancer certified? Have you previously applied? If not, please explain.

Describe how your oncology practice participates in Quality Oncology Practice Initiative (QOPI)? If it does not participate, please explain.

Currently, what is your process for sharing quality and safety reports within your oncology practice?

Are near misses and adverse events tracked and if so, how is this information shared?

Apart from near misses and adverse events, does your oncology practice track any quality improvement data? If so, describe the process for tracking any of the following:

- Handoff failures
- Patient and patient caregiver satisfaction scores
- Hand hygiene rates
- Patient falls
- CLABSI rates

Does your oncology practice share results of the quality improvement data? If so, describe the process and recipients.

In the setting of a merger or affiliation, how do you envision sharing quality reports between oncology practices?

How do you envision sharing safety reports between oncology practices?

Are oncology nurses trained on the identification and management of oncology patient risk?

- What topics does the training cover?
- What other clinicians attend these trainings?

Before starting chemotherapy:

- Are there checklists in place to aid in the review of patient's medical records? If so, please describe the checklists.
- Is there a standardized pre-treatment assessment process? If so, please describe the pre-treatment assessment process.

Describe your practices related to medication safety. For example:

- How does a provider initiate chemotherapy?
- How does a provider modify chemotherapy?
- How do providers calculate drug doses?
- What guidelines exist related to the expression of drug names?
- What guidelines exist related to the expression of drug doses?
- What processes are in place to ensure patients receive the correct medications in the correct dosages? How well do these processes work?
- How does your oncology practice ensure that chemotherapy orders are correct? What processes are in place?
- Are there systems in place to track patient opioid use?

What committees (both within and beyond your practice group) does your oncology practice participate in regarding quality improvement?

What committees does your oncology practice participate in regarding patient safety?

How do you ensure that all staff are up to date on patient safety knowledge?

How do you ensure that all staff are up to date on patient safety practices?

How do you ensure that all staff are up to date on quality improvement knowledge?

How do you ensure that all staff are up to date on quality improvement practices?

Do you report your cancer cases to any outside agencies? If so, which ones (e.g. state Department of Health)? What is the process for reporting? Who in your practice is accountable?

EMERGENCY SITUATIONS

What are the standard processes for getting help if a medical emergency happens during a chemotherapy session? (i.e. Do you call 911? Do you have a hospital emergency response team?)

How can you find the exact institutional policies for emergency situation triage and management?

Describe the criteria for urgently evaluating patients receiving chemotherapy

Describe the protocols for urgently evaluating patients receiving chemotherapy

Do protocols exist to direct the emergency treatment of:

- » hypersensitivity reactions?
- » overdoses?
- » life-threatening toxicities related to certain types of chemotherapy?

In what situations are the protocols used?

In what situations are the protocols not used?

What training is provided to staff to address emergency situations?

What disciplines should be involved in handling emergencies?

- » Of those, what would be each of their core roles/responsibilities during an emergency?

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