TO DRIFT IS HUMAN

In a recent article by David Marx, “Reckless Homicide at Vanderbilt? A Just Culture Analysis” (Outcome-eng.com, http://bit.ly/2TflzBbVanderbilt), the author discusses the propensity for humans to ‘drift’ into unsafe behavior. Marx goes so far as to say that instead of the Institute of Medicine calling its seminal report, “To Err is Human,” it should more accurately be called “To Drift is Human.”

In a Just Culture, this drift is called at-risk behavior. Marx believes that, along with system design, addressing at-risk behavior should be the primary focus of a hospital’s patient safety program. The inescapable human error, states Marx, is less of an issue than the human tendency to drift into at-risk behavior.

This article centers around a nurse working at Vanderbilt Medical Center who made a fatal medication error, when she gave a patient Vecuronium, a paralytic drug, instead of Versed, an intravenous sedative. The patient, who was about to have a positron emission tomography (PET) scan, was anxious, and her physician ordered Versed to calm her nerves. The nurse, RaDonda Vaught, overrode the automated medication dispensing cabinet when she did not find the medication under the patient’s profile (it was listed under its generic name). The nurse, RaDonda Vaught, overrode the automated medication dispensing cabinet when she did not find the medication under the patient’s profile (it was listed under its generic name). In the override search, Ms. Vaught typed in “VE” and clicked on the first drug that appeared – Vecuronium. She did not confirm the drug at the time of removing it from the cabinet, she did not confirm the drug at the bedside and she did not stay with the patient to monitor her reaction to the drug. Ms. Vaught has been charged with reckless homicide in the death of this patient.

Marx’s thought-provoking analysis of this event points out the difference between recklessness – the conscious disregard of a substantial and unjustifiable risk – and human error or at-risk behavior. Human error, in a Just Culture, is unintended behavior that is the result of a slip, lapse or mistake (such as not stopping at a stop sign that you don’t see). At-risk behavior is when an action is taken where the risk is not seen or is mistakenly believed to be justified (akin to choosing to drive 9 miles over the speed limit).

TO DRIFT IS HUMAN (Cont.)

Few of us could attest to never engaging in at-risk behavior. As David Marx points out, going a few miles over the speed limit means that one is violating the rules of the road. The degree of at-risk behavior is the issue. Humans tend to ‘drift’ toward higher at-risk behaviors over time, particularly if previous at-risk behaviors did not lead to a negative consequence. In healthcare, at-risk behaviors can include such things as workarounds for a policy/procedure that impedes day-to-day operational realities; failing to follow hand-washing requirements; skipping a surgical time-out; and, as in RaDonda Vaught’s case, overriding a patient’s profile in a medication dispensing cabinet.

Members of the safety community have expressed concerns regarding the State of Tennessee’s determination of criminal recklessness in the case of RaDonda Vaught. Seen through a Just Culture lens, unintended actions of a nurse, Ms. Vaught, led to an unintended, tragic outcome; the death of a patient. In a Just Culture, focus would be on mourning the death, consoling the nurse and fixing the system. Marx states: “RaDonda Vaught is facing prosecution for being what the prosecutor and grand jury see as the healthcare equivalent of the drunk driver who runs a red light, killing a helpless pedestrian in a crosswalk.”

In review of sentinel events or near misses, identifying when at-risk behavior has contributed to the event can identify where drift is occurring in the organization. This provides the organization with the opportunity of identifying what might be contributing to the drift, to address system attributes that contribute to the drift and to provide feedback to staff members who may be exhibiting at-risk behaviors.
**ECRI 2019 TOP 10 PATIENT SAFETY CONCERNS**

The ECRI Institute is an independent nonprofit organization, and an authority on the medical practices and products that provide the safest, most cost-effective care, and is one of thirteen Evidence Based Practice Centers designated by the Agency for HealthCare Research and Quality. ECRI has published its Top 10 Patient Safety Concerns for 2019, which are derived from the data regarding patient safety events and concerns identified through their Patient Safety Organization (PSO) and partner PSOs. [https://www.ecri.org/landing-top-10-patient-safety-concerns-2019](https://www.ecri.org/landing-top-10-patient-safety-concerns-2019)

ECRI suggests using this list as a starting point for conducting patient safety discussions and setting organizational priorities. Hospitals and other healthcare organizations that identify similar issues may find the recommendations in the report helpful to develop mitigation strategies. The report also includes links to other ECRI resources, some available without charge. This article will outline the top 10 patient safety concerns listed in the ECRI report.

1) **Diagnostic Stewardship and Test Result Management using Electronic Health Records (EHR)** – three key components must be clearly communicated through the EHR, and in a manner that future clinicians can look at the EHR and understand it. These components are: diagnosis, treatment plan and follow up plan. Faulty information or missing test results can lead to making diagnostic errors. “If you don’t get the diagnosis right, appropriate care cannot follow.”

   (As basic as this may seem, the SET continues to see inaccurate, incomplete or unclear EHR entries as causal factors to sentinel events.)

2) **Antimicrobial Stewardship in Physician Practices and Aging Services** – the most significant challenge facing antibiotic stewardship is managing patient expectations. Patients expect to be prescribed antibiotics, even if this would be an inappropriate treatment for their condition. ECRI suggests giving patients a ‘prescription for what to do and what to watch for.’ Organizations should implement and support antimicrobial stewardship programs.

**ECRI 2019 TOP 10 PATIENT SAFETY CONCERNS (Cont.)**

3) **Burnout and Its Impact on Patient Safety** – burnout is indiscriminate and can affect physicians, nurses, clinical support staff and organizational leaders. Burnout has a consistent, negative relationship with safety and quality. Contributing factors to burnout include: EHR and documentation frustrations; time pressures; caring for increasing numbers of patients with complex medical conditions and drawing on limited resources. To be addressed effectively, organizations need to listen to concerns of providers regarding workload, performance criteria and suboptimal resource allocation and fix these problems at a system level.

4) **Patient Safety Concerns Involving Mobile Health** – while mobile health technology presents opportunities to transport healthcare from traditional settings into the home, it comes with risks. Lack of regulation of new technologies, barriers to providers receiving the data a device is supposed to collect and the potential for incorrect use of the technology are some of the risks associated with mobile health technology. Organizations that are considering mobile technology must identify the right candidates for its use, provide training for providers and patients on use of the device; and develop methods for informing clinicians about user error and inactivity.

5) **Reducing Discomfort with Behavioral Health** – people with behavioral health needs are in every healthcare setting. However, in many healthcare settings behavioral and physical health are siloed. ECRI recommends training, developing opportunities to practice how to address behavioral health needs, and developing internal and external support systems. Examples of the latter include: behavioral emergency response teams for hospitals, training ‘specialist’ CNAs for working in aging services and process changes in physician practices. As posited by ECRI patient safety analyst, Nancy Napolitano, “How do we change the mindset so that everyone belongs here and is treated with dignity and respect?”

6) **Detecting Changes in a Patient’s Condition** – failure to detect changes in a patient’s condition can often occur during transitions of care, but can also happen within a care unit. This can lead to significant problems and patient harm. Staff
must be trained to recognize changes in a patient’s condition, how to conduct patient assessment and communication skills. Team training, patient safety huddles and rounding at the patient’s bedside all promote information sharing. Staff should be encouraged to listen to the concerns of patients and their families, and serve as patient advocates.

7) Developing and Maintaining Skills – patient harm can occur if staff are uncomfortable or inexperienced using medical equipment, performing procedures or are unaccustomed to care processes within the organization or care area (for example, locums, travel staff and new employees). Simulation training can offer opportunities for healthcare providers and staff to practice their skills. ECRI states that studies have proven that patient outcomes can be improved using simulation-based education, and simulation training does not need to be costly or complex.

8) Early Recognition of Sepsis Across the Continuum – early recognition of sepsis is vital because sepsis can quickly become fatal. While early recognition of sepsis in hospitals has received a lot of attention, ECRI promotes recognition of sepsis throughout the continuum of care. CNAs can be trained to use screening tools and physician practices can screen for sepsis both in the exam room and on the phone. Organizations can use checklists, tools or algorithms to support the early recognition of sepsis.

9) Infections from Peripherally Inserted IV Lines – peripheral intravenous (PIV) catheters are commonly used in healthcare, and are often inserted upon admission as a matter of course, in case the patient needs IV therapy at some point. PIVs can expose patients to a significant risk of infection – one ECRI states is underreported, underrecognized and ignored. Tracing infections back to PIV lines can be difficult, in part because healthcare workers tend to overestimate their safety. Staff should slow down and assess whether a patient actually needs a PIV catheter inserted.

10) Standardizing Safety Efforts across Large Health Systems – as health systems get bigger and more complex, there are associated safety risks. System-driven reporting and quality initiatives should be implemented thoughtfully, with recognition that this could add layers to organizational processes. Regardless of the size of the organization, the goal should be to institute structures that effectively allow patient safety leaders to support organization leadership in engaging with patient safety priorities.

ECRI also points out the benefits of PSOs, which offer protection from discovery. The Patient Safety and Quality Improvement Act of 2005 (PSQIA) enables all licensed or certified healthcare facilities and clinicians to participate in a PSO and take advantage of the privilege and confidentiality protections it affords. These protections are uniform nationwide. The Sentinel Event Program offers similar protection to those healthcare providers mandated to report sentinel events.

THE CURSE OF KNOWLEDGE

In a recent article in the New England Journal of Medicine ("Cursed by Knowledge – Building a Culture of Psychological Safety" N Eng. L Med, February 2019), Lisa Rosenbaum, M.D. discusses the concept of ‘the curse of knowledge.’ Simply put, when we have a lot of knowledge about something, it is difficult to recognize that someone else does not have the same understanding. There are many examples of this in healthcare, most notably the disconnect that can happen with physicians and patients. For example, a specialist immersed in her profession for several decades may think that she is adequately explaining the risks/benefits of treatment to a patient, but the language and terms that she uses may be something the patient cannot understand.

The ‘curse of knowledge’ also impacts the ability of healthcare professionals to communicate effectively with one another. Organizational psychologist, Chip Heath points to specialization as a key element leading to the curse of knowledge. With thousands of medical procedures and prescribe-able drugs, the level of complexity forces specialization. However, specialization comes at the cost of integration – specialists develop their own language. When multiple physicians are involved in the care of a patient, the curse of knowledge can impede the coordination of care. Even among doctors, or perhaps especially among doctors, there can be hesitancy to seem less knowledgeable than one’s peers.

Amy Edmondson, a teamwork expert at the Harvard Business School, has found that teams who worked most effectively together had leaders who consistently acknowledged and spoke out about their lack of omniscience. This isn’t easy, as Edmonson points out – there is a need to balance the need to
seek help against the possibility of appearing stupid. As Abraham Lincoln quipped, “Better to remain silent and thought a fool than to speak out and remove all doubt.” Yet this failure to be willing to appear fallible, either as a patient or a clinician, dramatically impedes communication and shared knowledge and can lead to serious adverse events.

Rosenbaum points to a more consequential curse of knowledge; what she calls healthcare’s myopic approach to knowing. As an industry, healthcare generates knowledge by measuring those things that can be counted: days lived, errors, avoided, etc. While this data may help to understand certain features of the delivery system, they fail to capture the cultural and interpersonal dynamics that shape the ‘capacity to care.’ Patients expect their healthcare providers to work together to provide the best care possible. Unfortunately, this often does not happen, in part because of deeply entrenched individualistic ethos. Rosenbaum concludes her article by stating that individualist-based solutions continue to obscure an important question: How does the culture of medicine shape what doctors become and how they behave?