

ASHRM Patient Safety Tip Sheet: Normalization of Deviance in Healthcare



Situation: Normalization of deviance is the gradual process of deviating from standard operating procedure (SOP) for various reasons and the deviation becomes the norm as no immediate adverse outcomes occur. Normalization of deviance in patient care has the potential for devastating outcomes. It plays a unique role in health care as the very safety practices and a larger culture of safety meant to prevent deviation from SOP are not as widespread as early patient safety movement proponents anticipated.

Background: Normalization of deviance is a term most notably described by sociologist Diane Vaughn in her analysis of the 1986 Challenger disaster. While the infamous “O-rings” were found to fail, extreme pressure to meet the launch date resulted in normalization of deviance across time, ranks, and disciplines and deemed the root cause of the disaster (Vaughn 1996). Vaughn further described the term as, “social normalization of deviance means that people within the organization become so much accustomed to a deviation that they don’t consider it as deviant, despite the fact that they far exceed their own rules for elementary safety.” An analysis of 245 closed medical specialty claims 2003-2012 found three common themes, (1) impaired culture of safety, (2) violations of standards of care, and (3) impaired patient safety and outcomes (Everson, Willbanks, & Boust 2020).

Assessment: Normalization of deviance is most prominent where a culture of patient safety is not fully established. As the Challenger disaster example portrays, the “groupthink” phenomenon that makes deviating from SOP acceptable across an organization can be readily applied to health care. One of many examples is the continued occurrence of wrong site, patient surgery. Its occurrence is often falsely attributed to the verification process being faulty (Vitale, Sethi, Wang 2020). Some accusations include the checklist being inadequate despite not being fully vetted or utilized and/or the “time-out” not working despite being performed without all team members in the room, and/or site marking failure despite it not being within the field-of-vision among other accusations. This group rationalization stems across all specialties and disciplines and so often normalization of deviance is the root cause and not faulty well-established processes.

Recommendation: To embrace a culture of patient safety that obliterates normalization of deviance as a root cause of adverse events, an organization must first analyze its current culture and act upon the results in a fully transparent fashion. By leadership first embracing the need to do so and being fully present on the journey while engaging the workforce to participate, transformation can occur. Use of change management practice allows for structured process improvement. Change management will identify principles and pillars to embrace a just, accountable, transparent, learning, and patient-engaged culture, all the necessary ingredients to omit the practice of normalization of deviation.

References:

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ASHRM Patient Safety Tip Sheet: Technology and Patient Safety



Situation: Technology plays a critical role in the delivery of care and prevention of adverse events. Health care organizations must maximize the benefits of patient safety technologies through carefully designed processes, efficient implementation and ongoing monitoring to ensure use of technology as intended.

Background: In June 1998, the Quality of Health Care in America project aimed at addressing quality related issues and re-designing the health care delivery system for the 21st century. Shortly thereafter the Institute of Medicine published *To Err Is Human* highlighting the need to understand the learnings from high-risk industries regarding safety and developing 5 key principles for safe health care: (1) leadership (2) respect for human limits in the design process (3) promoting effective team functioning (4) anticipating the unexpected and (5) creating a learning environment.

Assessment:

- Technology has been described as a potential barrier in promoting safer health care due to a number of pitfalls that may occur when introducing new technology:
 - Poor design not adhering to human factors and ergonomic principles of the end-user
 - Poor interface with the patient or the environment
 - Inadequate plans for implementation of the new technology into practice
 - Inadequate maintenance of the implementation plan
- Unintended consequences of new technology such as “workarounds” or temporary fixes due to poor distinction between the ‘work that is imagined’ and the ‘work that is actually done’, causing potential for an increase in the opportunities for errors over time
- The most optimal equipment/technology, if not well integrated into the current delivery system or implemented in a chaotic way, can result in unexpected costs and increased errors.

Recommendation:

- Utilize ergonomics and human factors engineering (HFE) in the design/implementation
- Ensure clinical and subject matter experts are included in design and testing of new technology
- Integrate HFE with existing workflows to make interfaces easy to learn and use high-stress situations
- Involve direct care providers in the policies and processes for maintenance, training, monitoring and reporting of adverse events related to technology
- Examine performance of technology use through simulation of challenging scenarios
- Mentor and oversee temporary staff during first-time use of new technology
- Ensure users evaluate technology to identify and communicate problems early

References:

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ASHRM Patient Safety Tip Sheet: Patient Safety Organizations



Situation: You are committed to making health care safer and better for your patients. One of the challenges to achieving this goal is the concern that information generated by patient safety and quality improvement processes could be used against you or your organization. Working with a Patient Safety Organization (PSO) listed by the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Department of Health and Human Services (HHS) can help.

Background: The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) authorized the Federal certification and listing process for PSOs. Providers (individual health care professionals, group practices, health care facilities and others) that choose to work with a PSO can obtain uniform Federal confidentiality and privilege protections for information that meets the definition of patient safety work product. AHRQ administers the PSO listing process, but the government is not involved in the PSOs' work with providers. Each PSO and the providers it works with determine the scope of the improvement activities they will do together under the Patient Safety Act and Rule.

Assessment: Working with a federally listed PSO is voluntary and offers several unique advantages:

- With certain exceptions, patient safety work product is confidential and not subject to Federal, State, or local subpoena or discovery; may not be admitted as evidence in criminal, civil, administrative, or disciplinary proceedings; and is not subject to the Federal Freedom of Information Act or similar State and local laws. Federal confidentiality and privilege protections for patient safety work product apply in all U.S. States and territories, and across state lines.
- Over half of general acute-care hospitals participating in Medicare work with a PSO, and nearly all find this valuable, according to a study conducted in 2018 by the HHS Office of the Inspector General.* Among hospitals that work with a PSO, 80 percent find the analysis and feedback regarding patient safety events helpful in preventing future events.
- PSOs aggregate and analyze data from multiple providers. This enables the PSO to detect patterns not visible from smaller numbers of organizations and has the potential to uncover serious and rare events sooner. A provider may work with a PSO in any location (for example, from your state or another state) and may work with more than one PSO. PSOs and providers that use AHRQ's Common Formats (standardized definitions and formats) in their work together can contribute to national learning about patient safety by volunteering non-identifiable data for inclusion in the network of patient safety databases (NPSD).

Recommendation: Learn more about working with a PSO:

- Search for federally listed PSOs at: www.pso.ahrq.gov/listed
- Learn more about the Patient Safety Act and PSOs by visiting: <https://pso.ahrq.gov/>
- Consider using existing AHRQ Common Formats, available at: https://www.psoppc.org/psoppc_web/publicpages/commonFormatsOverview. Review and comment on new ones at: http://www.qualityforum.org/Project_Pages/Common_Formats_for_Patient_Safety_Data.aspx
- Explore the patient safety data currently in the NPSD, available at <https://www.ahrq.gov/npsd/index.html>. Use the interactive NPSD Dashboards and review the NPSD Chartbooks that provide an overview and highlight data patterns and trends.
- Questions? Contact the AHRQ PSO Program team at pso@ahrq.hhs.gov.

* Office of the Inspector General of the Department of Health and Human Services. Patient safety organizations: hospital participation, value, and challenges. OEI-01-17-00420. September 2019. <https://oig.hhs.gov/oei/reports/oei-01-17-00420.pdf>

ASHRM Patient Safety Tip Sheet: Value of Incident/Event Reporting



Situation:

The limitations of voluntary incident/event reporting systems are well documented. Incident/event reports are subject to selection bias due to their voluntary nature. When a medical record review and direct observation are completed, it was found that incident/event reports captured only a small percentage of incident/events and may not reliably identify serious events.¹

Background:

Patient safety incident/event reporting systems are a backbone of efforts to detect patient safety events and opportunities for quality improvements. "Incident reporting is frequently used as a general term for all voluntary patient safety event reporting systems, which rely on those involved in events to provide detailed information. Initial reports often come from the frontline personnel directly involved in an event or the actions leading up to it (e.g., the nurse, pharmacist, or physician caring for a patient when a medication error occurred), rather than management or patient safety professionals."²

Assessment:

Incident/event reporting adds value to an organization's awareness. Incident/event reports document the details of an event or process that are typically not included in the medical record. Joint Commission and the Centers for Medicare and Medicaid Services (CMS) requires facilities to have a way to track adverse events; incident/event reporting process satisfies these requirements. Some states also have requirements related to incident/event reporting or adverse event reporting. Lastly, incident/event reporting systems provide a means for frontline personnel to report safety hazards.

Recommendations:

Important Concepts related to Incident/Event Reporting:

- Incident/event reports should be filed for any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Incident/Events include errors, adverse events, near misses and hazards.
- Incident/event reports are risk management tools to gather and trend data.
- Reports are escalated to leaders who assist in evaluating the processes and systems related to the reported event. Changes in processes to prevent similar errors or adverse events should be explored.
- Reporting systems that encourage residents and physicians to report incident/event and close calls provide value in the identification of processes needing evaluation.

Additional Resources:

Patient Safety Primer: Reporting Patient Safety Events found on the Agency for Healthcare Research and Quality website (updated September 2019). <https://psnet.ahrq.gov/primer/reporting-patient-safety-events>

Incident Reporting Systems - Adverse Events: Reporting and Prevention by Tom Inglesby (October, 2014) <https://www.psqh.com/analysis/incident-reporting-systems-reporting-and-prevention/>

1. Cullen DJ, Bates DW, Small SD, et al. Incident reporting system does not detect adverse drug events: a problem for quality improvement. The Joint Commission journal on quality improvement. 1995.
2. AHRQ: Patient Safety Network, Reporting Patient Safety Events, September 2019. Retrieved from: <https://psnet.ahrq.gov/primer/reporting-patient-safety-events>

ASHRM Patient Safety Tip Sheet: Communication

Situation: The Joint Commission, Department of Defense, and other agencies have collected data identifies communication as the leading cause of sentinel events, which are the most serious adverse events. Communication failures contribute to 50-80% of sentinel events, according to the Joint Commission.¹

Background: Michael Leonard, MD, Physician Leader for Patient Safety, along with colleagues Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado (Evergreen, Colorado, USA), developed a communication technique using the mnemonic SBAR-Situation-Background-Assessment-Recommendation. This communication tool has been successfully implemented in various health care settings to promote teamwork and a culture of safety.

Assessment:

SBAR communication technique provides a framework for communication between members of the health care team about a patient's current condition. This model allows an easy and focused way to set expectations regarding what and how information should be communicated and shared. It is especially helpful during high anxiety situations that require immediate attention and/or action.

- **S = Situation** (a concise statement of the problem)
- **B = Background** (pertinent and brief information related to the situation)
- **A = Assessment** (analysis and considerations of options — what you found/think)
- **R = Recommendation** (action requested/recommended — what you want)

SBAR is an easy and effective way to enhance communication between individuals. It provides a concise, yet comprehensive message reducing the probability of error.

Recommendation:

On September 12, 2017, the Joint Commission released a Sentinel Event Alert regarding inadequate hand-off communication.² In addition to SBAR communication, the alert included some of the following recommendations:

- Standardize training on how to conduct a successful hand-off – from both the standpoint of the sender and receiver.
- Engage staff in training using methods such as real-time observation and performance feedback, role-playing and simulation, and independent learning.
- Identify champions and coaches to promote quality improvement and serve as role models.
- Provide positive reinforcement to employees who perform hand-offs according to the standardized process.

References:

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2. Inadequate hand-off communication. Sentinel Event Alert. 2017 Sep 12;(58):1-6.