



A Pathologists' Assistant Role in Patient Safety and Quality Improvement

THE UNIVERSITY OF TEXAS
MD Anderson
Cancer Center
Making Cancer History®

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There are no conflicts of interest to disclose.

My journey and future plan



Quinnipiac-PA school



Private practice-6 years



Baylor College of Medicine-15 years



MD Anderson-3 years

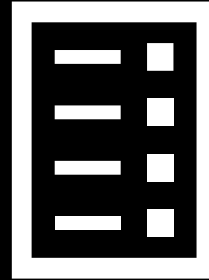


GOAL: Understanding patient safety quality improvement (PSQI) tactics applicable to future practice

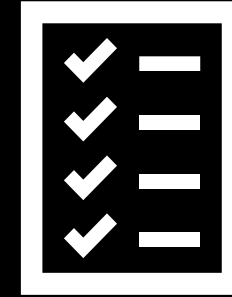
- **OBJECTIVES:** After this session, the attendee will be able to:
 - Describe history leading to PSQI methodologies
 - Identify common patient safety concerns observed in surgical pathology
 - Recognize how communication failures can impact patient safety and how PAs can bridge that gap
 - Describe a process of safety reporting with psychological safety in mind
 - Describe how early, mid or late-career PAs can obtain leadership competencies that align with future roles in PSQI

What's is QC/QA/QI?

Q. Control-program



Q. Assurance-pre-emptive measures



Q. Improvement-the intervention and monitoring





NURSES

PHYSICIANS

RISK MANAGERS

STATISTICIANS

PHARMACISTS

PSQI Team: Collaborative multidisciplinary unit in place to improve quality of patient care focusing on designing and redesigning care structures to improve outcome for the providers, health system as a whole, and most importantly, patients.



histotechs

Lab
managers/directors

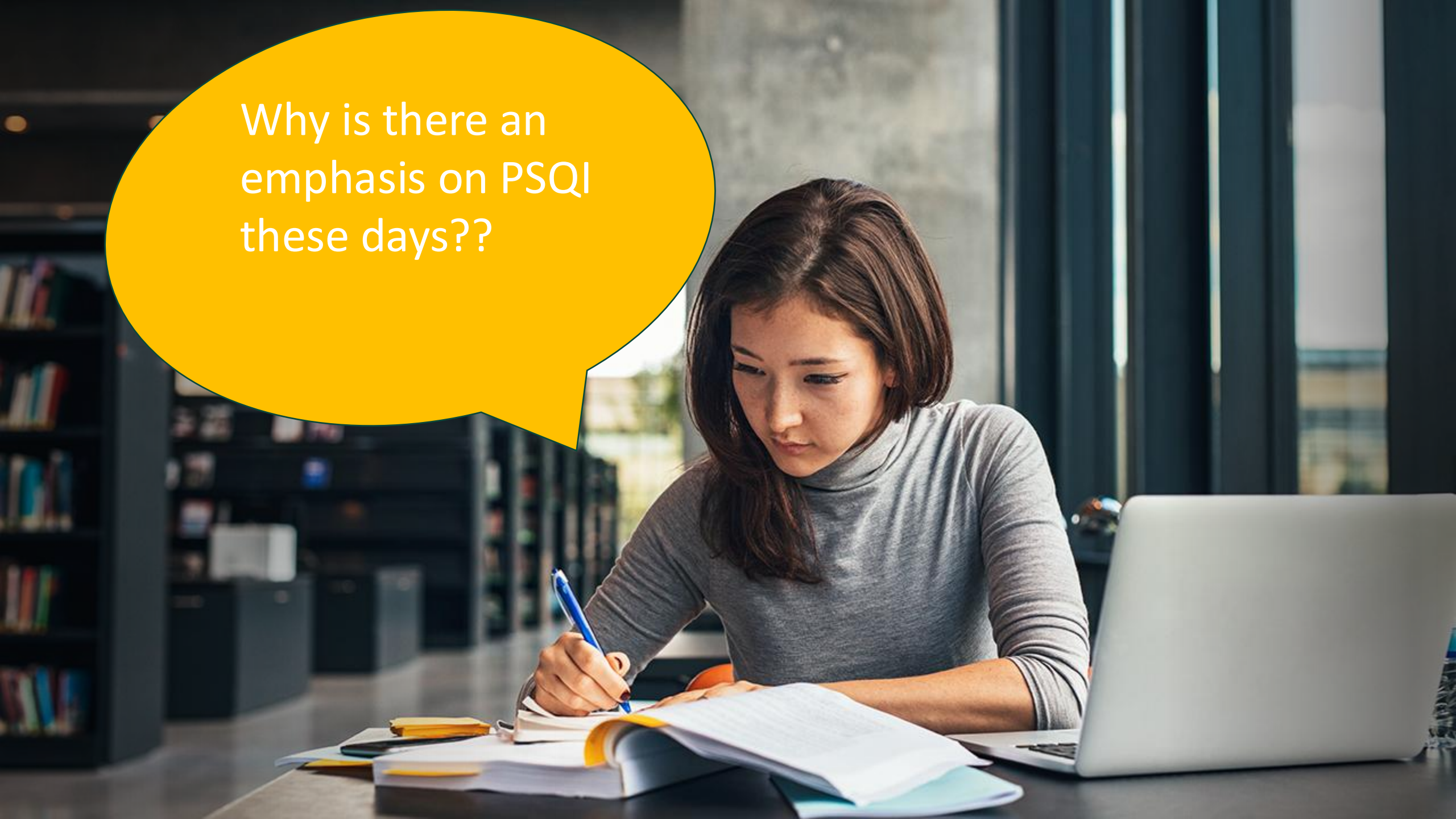
Quality managers

Medical lab scientists

Pathologists/PAs

PSQI Team- Pathology

Why is there an
emphasis on PSQI
these days??



National Academy of Sciences

(formerly Institution of Medicine)-*Crossing the Quality Chasm*



Why is US healthcare not better?
Why isn't there an emphasis in QI and
patient safety?



"highly complex web
of highly specialized health care professionals
who are all individually experts but who
are unaware of anyone else on
the [healthcare team] and how to work best
with them" (3)

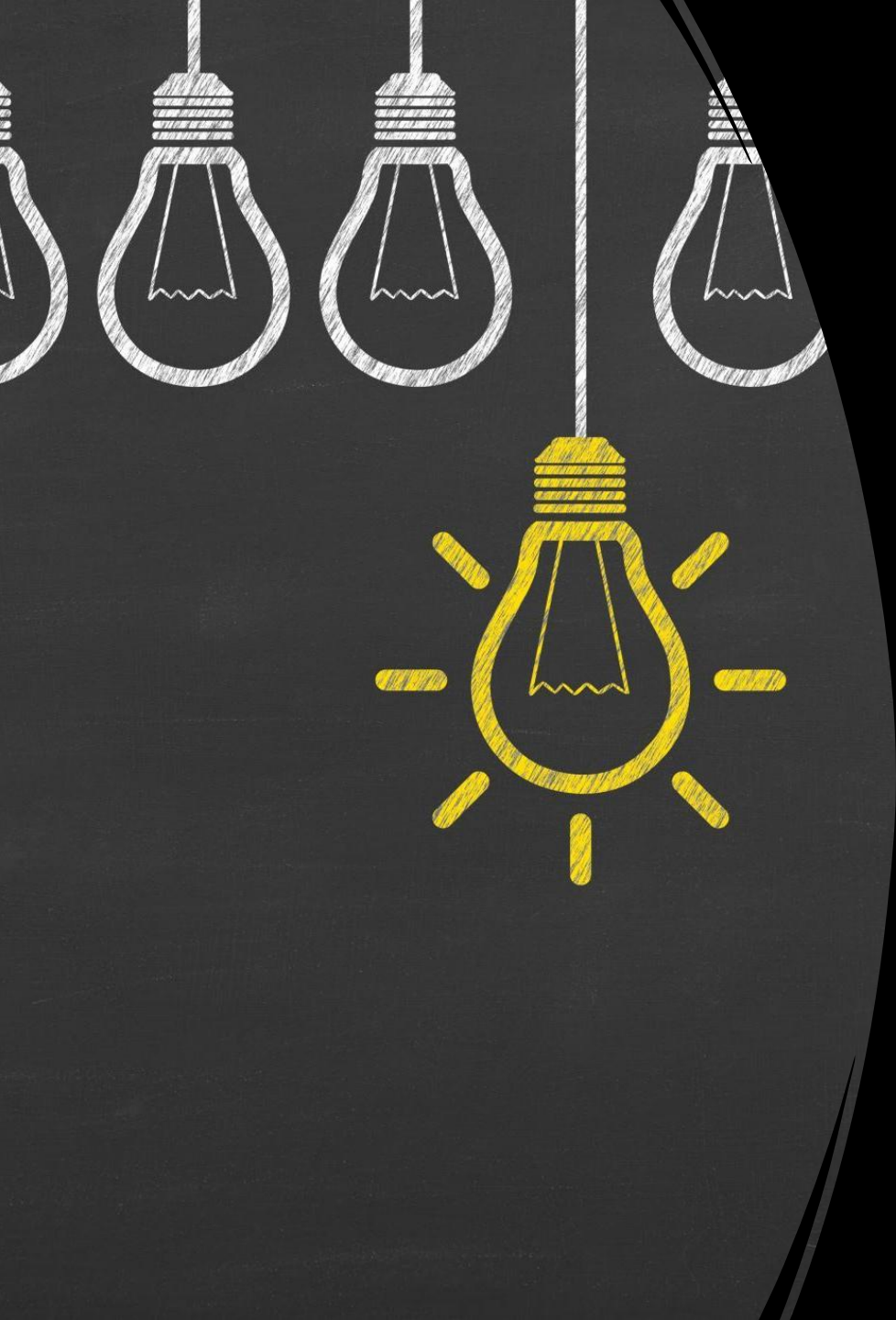
Other Problems:

- Association of American Medical Colleges (AAMC) encouraged PSQI programs. SOME medical schools had formal PSQI programs. (4)

A group of graduates in black caps and gowns, seen from behind, standing outdoors with trees in the background. Some are holding up phones to take pictures.

Accreditation Council of Graduate Medical
Education (ACGME) encouraged medical
education for PSQI.

Status: Only 50% of fellowships have training
due to the lack of faculty to train (5)



Reframing needed for medical education:

- Collaboration
- Continuous improvement
- Data driven/evidence based projects
- Patient-centered care demonstrated with case-based learning interlaced with traditional basic science and clinical skills
- Active learning: team-based, asking questions related to process improvement



Reframing needed

- New basic sciences: **error causation, human factors,** leadership, management (3)
- handful of US institutions have seen early success in integrating systems improvement learning into clinical learning

US National Academy of Medicine in 2015 (3)

Crossing the Quality Chasm

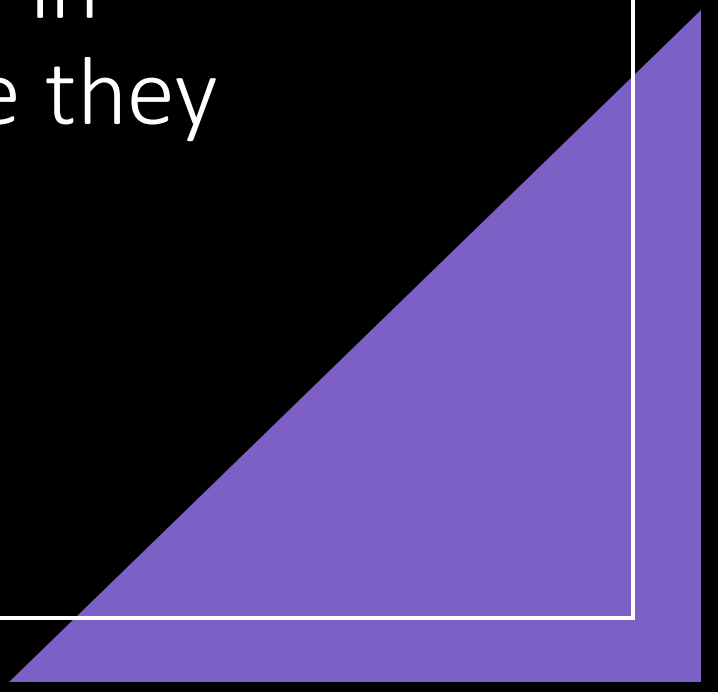
Looked at what kind of care people received

6 aims for improvement: To have safe, effective, patient-centered, timely, efficient, equitable care incorporated into daily activities

Process: focus was on safety with desired outcomes, those outcomes relied on evidence with continuing development

Process involves a team (3)

Once in practice, health practitioners may be employed in institutions encouraging systemic behavioral change like adopting **high reliability organization (HRO)** principles featured in PSQI programs to reduce errors before they occur and enhance patient safety.





Institutional Emphasis on Safety

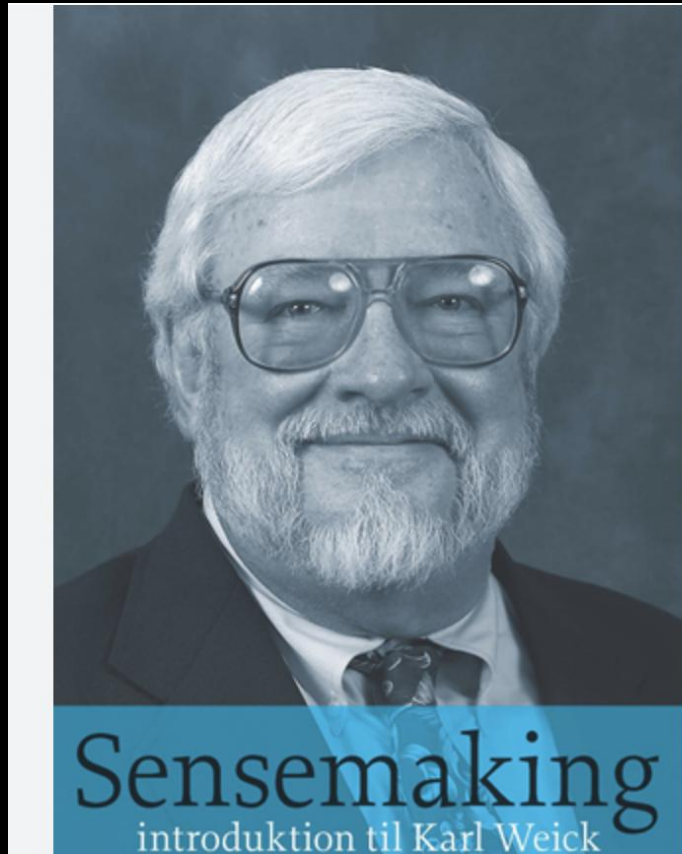
- Use HRO in mind which requires
 - Leadership commitment to have a strong safety culture in place using strategies like Lean Six Sigma (LSS) process improvement

Origin of HRO

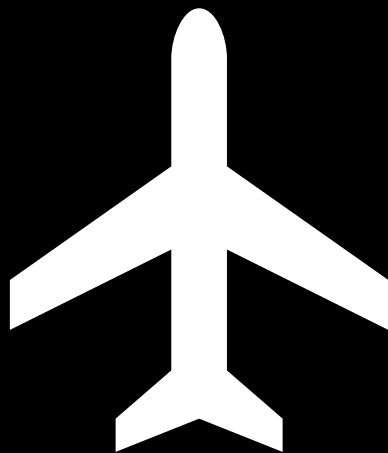
- 1984 UC Berkeley
- LaPorte, Rochlin, Roberts



WHAT IS HRO?



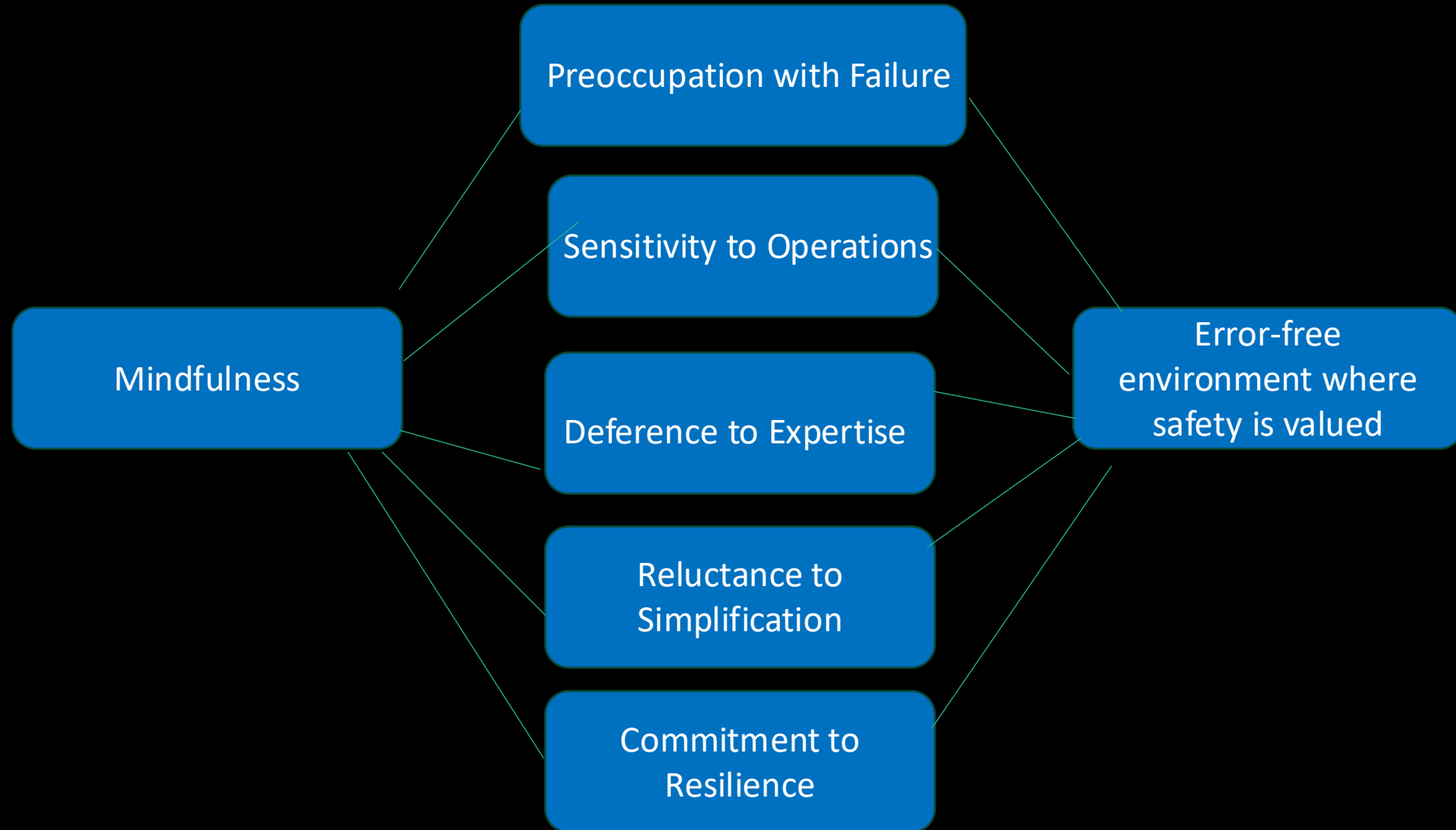
MANAGING THE UNEXPECTED (6)



described this process in
organizations operating in
high risk or hazardous
environments without
errors for an extended
time

value=safety within an
error-free environment (6)

HRO PROCESS/PRINCIPLES:





"bother me in the cockpit"

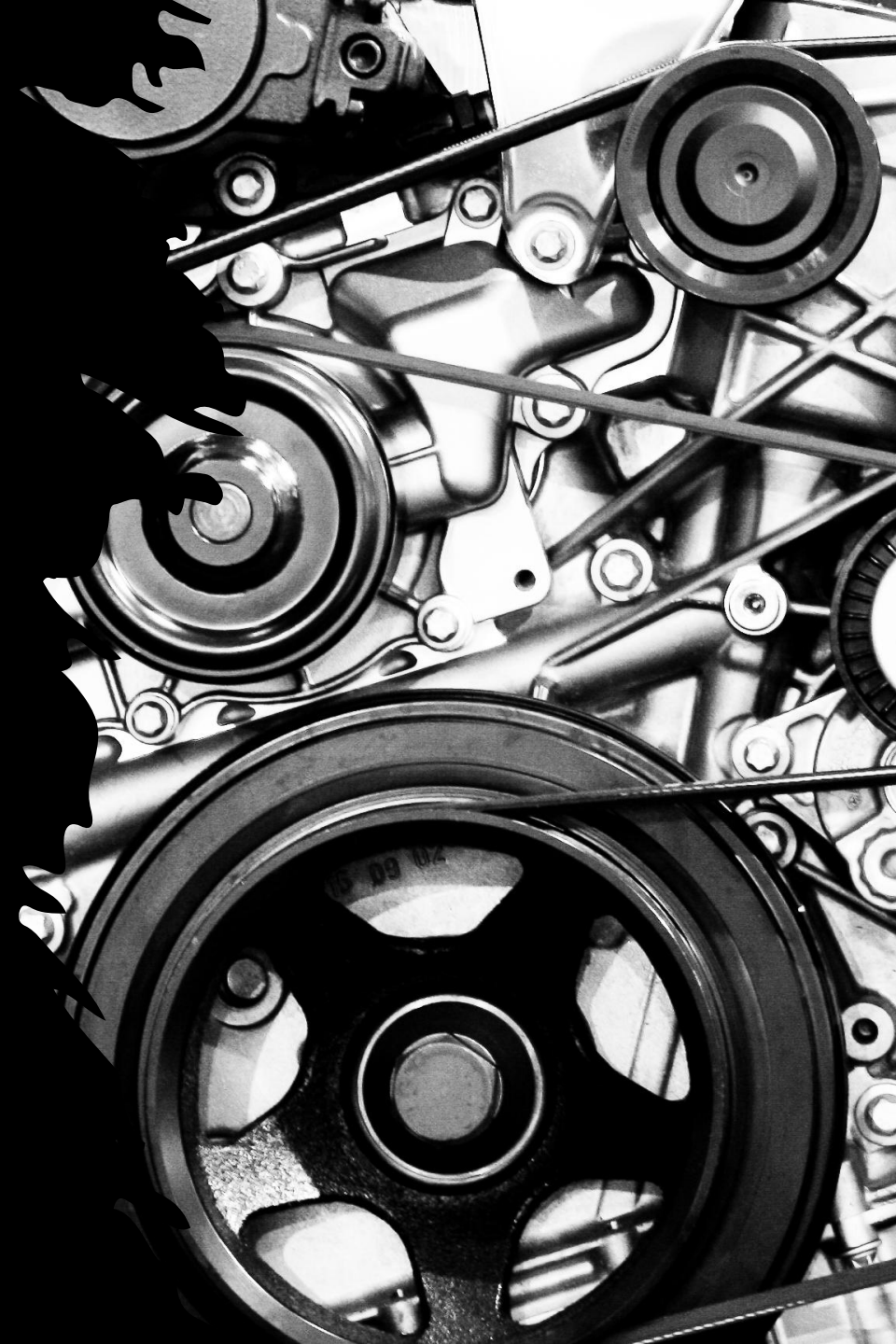


Close attention paid to the front lines in real time, taking immediate action re: adversity



Co-production, regardless of rank

organization is a
complex
organism-
rejecting the
status quo





Preparedness to combat adverse outcomes, maintain competency
of the team

What are the
foundational prompts to
apply HRO in medicine?

Healthcare Management + HRO



<https://business.vanderbilt.edu/bio/tim-vogus/>



<https://hub.jhu.edu/2019/12/03/still-not-safe-sutcliffe/>

Foundational Prompts-the quest to establish a "safety culture"



Vogus and Sutcliffe (2007) had shown “safety culture” organization in hospital nursing units by utilizing their Safety Organizing Scale (SOS) related to patient falls. The purpose of this study was to show that patient safety and “safety culture” was sustained by “supportive leadership” (8)



The Joint Commission announced **that** healthcare institutions **should attempt to reach HRO status**. A huge problem is the number of stratifications present in a healthcare system. (9)



According to the Joint Commission, all members and levels of an organization must share the same goal with their supportive leadership.

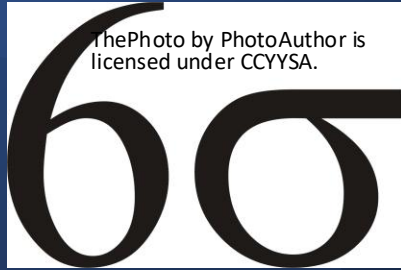
According to the Joint Commission,
all members and levels of an organization
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supportive leadership.

Quality Improvement Methodology

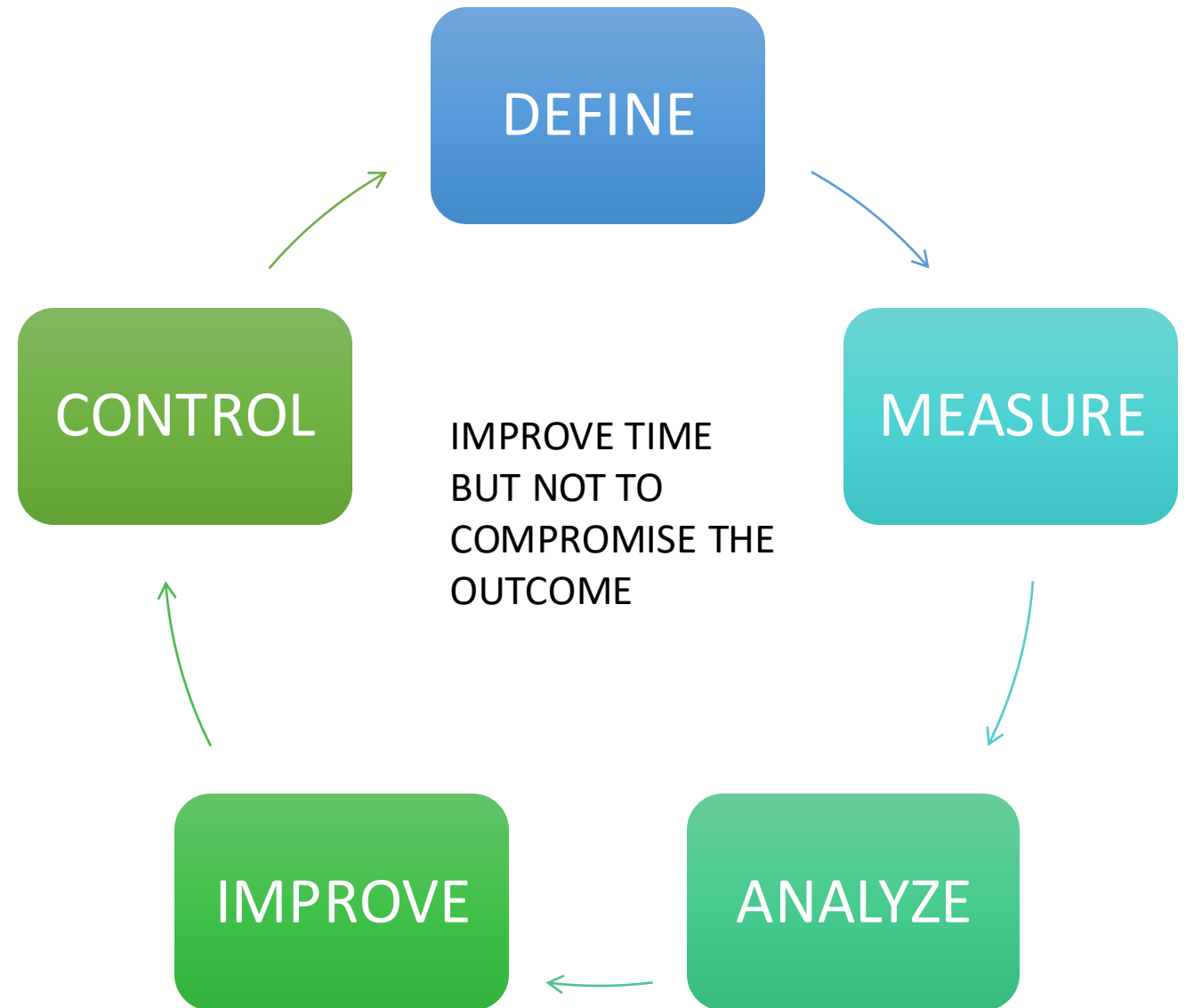
Robust
Process
Improvement
Methods (10)

Plan, Do, Study,
Act (PSDA)

Lean Method



Lean Six Sigma (6
SIGMA)-reduce
defects and variations
in operations (10)



LEAN SIX SIGMA BELTS

White Belt

Yellow Belt

Green Belt

Black Belt

**Master
Black Belt**

Team Member

Project Leader

Project Expert

Strategy & Coaching



WHAT CAN I DO AS A PA???

Common PSQI concerns observed in surgical pathology workflows

TAT without
compromising
patient safety

Patient identification

Carry over

Cassette
misplacement/order

Working on one
case at a time

Specimens
accidentally
discarded before
processing

Safety Officer

- Monitoring waste removal
- Spill kits
- SI events, intervention and continuous outcomes
- Quarterly meetings-interaction with CLIA directors
- Safety checks (eye wash safety shower works, disposal of hazardous waste)
- All donning and doffing PPE
- CAP Inspection
- Internal Safety Inspections



A time for
storytelling:
Championing frozen
section TAT, ischemic
time for breast tissue
and tissue for
banking.





THE UNIVERSITY OF TEXAS
MD Anderson
~~Cancer~~ Center
Making Cancer History®

Interprofessional Education with Anatomic Pathology

• Kristine McCluskey, EdD, MHS PA (ASCP)
• Division of Pathology & Laboratory Medicine
• Northwest Houston Surgical & Specialty Care



GOAL:

With partnership in mind, the pathology lab will describe the form and functions of the **pathology frozen lab** to your service to help provide optimal patient care with **rapid results**.

- **OBJECTIVES:** After this 10-15 minute session of interprofessional education, the learner will be able to:
 - Recognize the **key players** within the frozen lab
 - Describe the order of operations following **tissue transport**
 - Discover the national guidelines and the importance of **timely tissue transport** to the frozen lab for therapeutic intent and research purposes



Overview of a Pathology Department

BRANCHES:

Clinical Pathology

- Clinical Chemistry
- Microbiology
- Hematology
- Molecular Studies
- Cytology

- Anatomic Pathology
- Histology
- Autopsy
- Forensic Pathology



FROZEN!



PERMANENT



Pathology receives sample and evaluates macroscopic appearance



Sample representative areas for microscopic analysis



Processed **OVERNIGHT** and embedded in paraffin wax



Very thin sections cut on a microtome & placed on glass slide



H&E stain performed; slides ready to be reviewed!

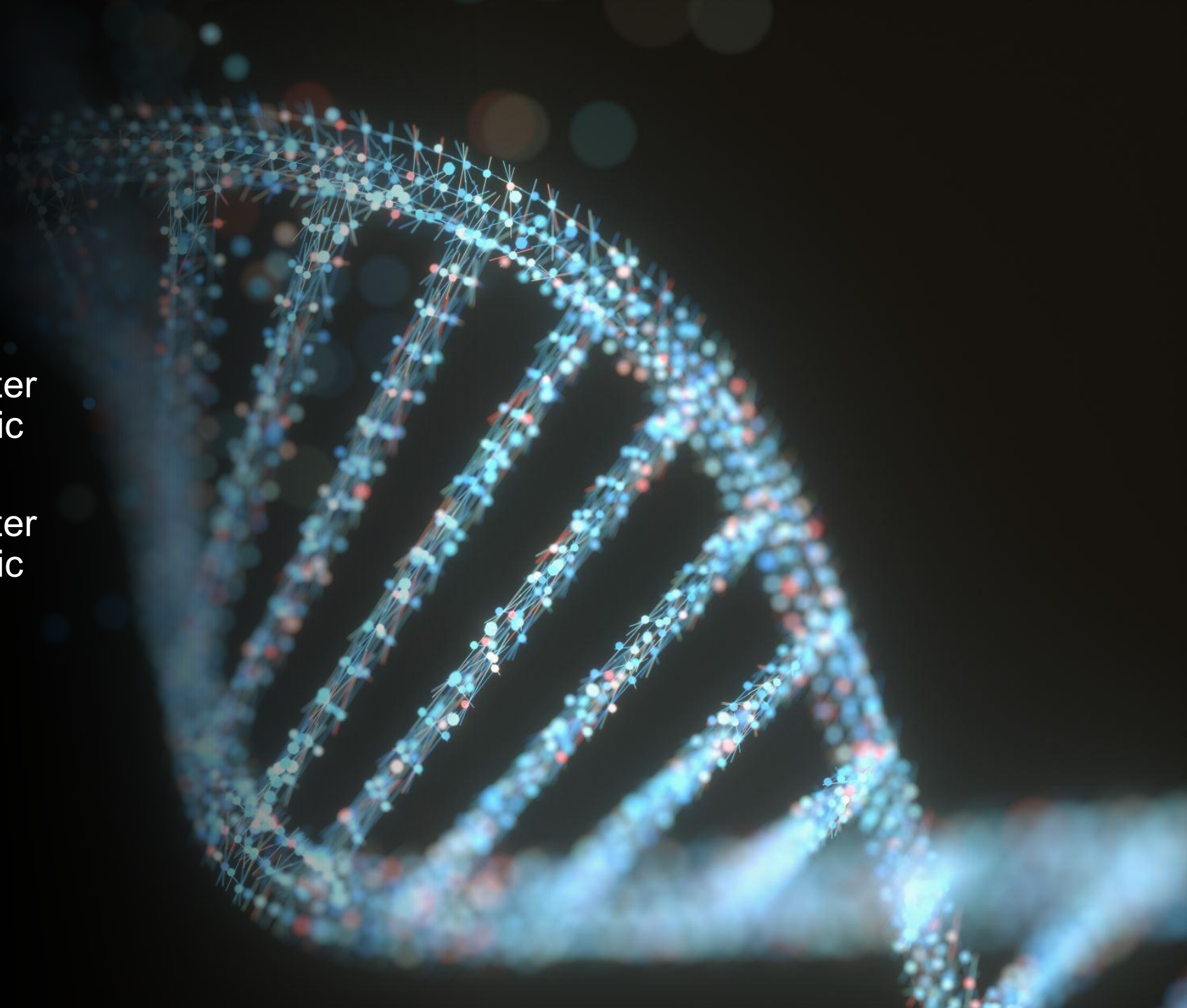
Time is of the essence!

- Tissue bank at least 10 minutes once out of the body (anoxic/ischemic)
- 20 minutes-if specimen is placed on ice, indirectly
- We must perform a frozen and intraoperative assessment first if requested which prolongs the ischemic time.
- Anoxic and fixation times are recorded.



DNA/RNA

- DNA begins to degrade after 60 minutes of cold ischemic time.
- RNA begins to degrade after 30 minutes of cold ischemic time.

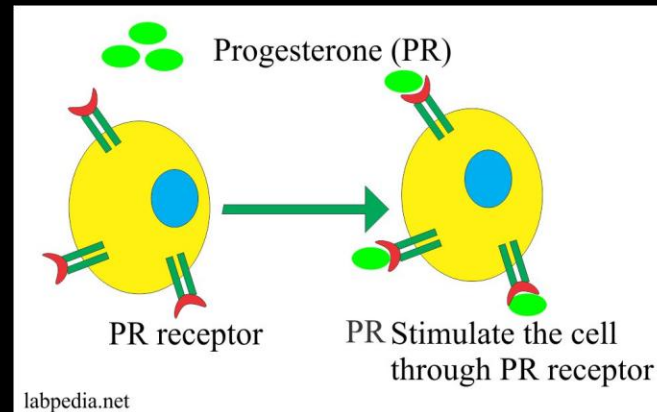


EVIDENCE-BASED GUIDELINES: BREAST TISSUE ISCHEMIC TIME



Why is ischemic fixation time important especially for breast cancer and why is it to be monitored?

- ER, PR, HER2 biomarkers determine a patient's treatment options



- ER, PR, HER2 negative patients have limited options
- American Society for Cancer Oncology and College of American Pathologists guidelines-HER2 (human epidermal growth factor) strongly recommend a fixation by one hour. (12)

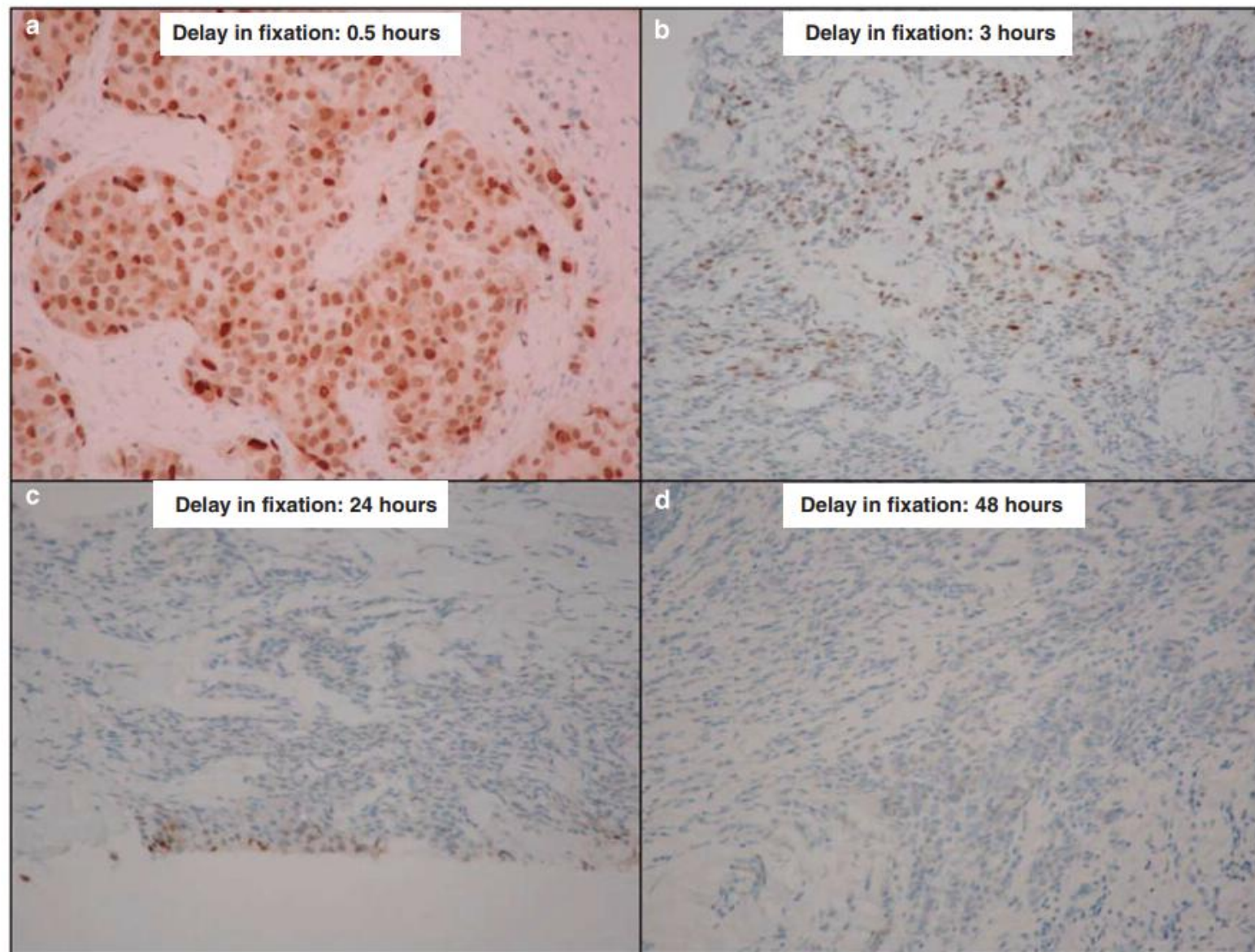
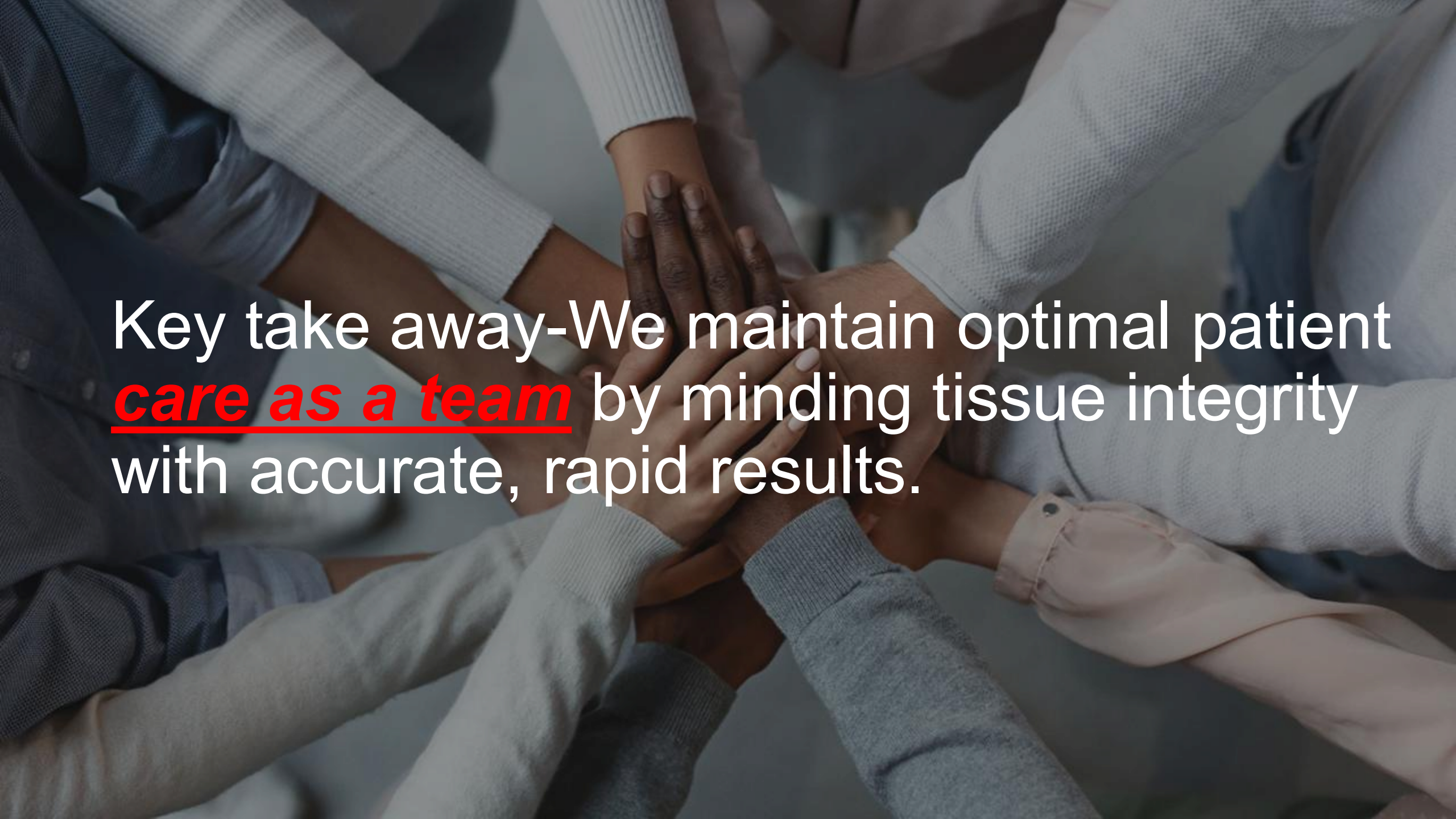


Figure 2 Same case as Figure 1. The tumor showed moderate reactivity for progesterone receptor (similarly to core biopsy) at 0.5 h of delayed fixation (**a**), but demonstrated significant reduction at 3 h (**b**). Only rare cells at the tissue edge stained for progesterone receptor at 24 h (**c**), and the tumor was completely negative at 48 h (**d**). All photomicrographs were taken at $\times 200$. **11**

A close-up, top-down view of several hands of different skin tones (white, light brown, dark brown) being stacked on top of each other in a circular arrangement. The hands are wearing various colored sleeves (white, grey, blue, pink). The background is blurred, showing more people in a similar setting. The overall tone is professional and collaborative.

Key take away-We maintain optimal patient *care as a team* by minding tissue integrity with accurate, rapid results.

As a form of communication across practices and internally, a PA can **report safety events**

*****BREAK TO POLL RESULTS*****

What is a safety event-"SI" event?

- Significant Incident (SI) event?
(Concern, Uncomfortable, Safe)
- Anyone can report
- Write the facts-consider the lesson learned
- Exclude names in the description of the event



REPORTING IS SAFE
PRACTICE!

OTHERS MAY NEVER LEARN FROM OUR MISTAKES
UNLESS REPORTED, DISCUSSED, AND SOLUTIONS ARE
IN PLACE!





Info Center



Tasks



New File



File Tracker

Icon Wall

Find a form

Please use the search box to narrow down the event type results by using keywords to describe the event.

When submitting this report as Anonymous, you are electing not to receive any follow-up information on the status or resolution of this event.

Since we cannot track who submits these reports, please add as much detail to facilitate a proper investigation. The Patient Safety Department will thoroughly investigate all anonymous reports. Thank you for your submission and commitment as we move toward high reliability through transparency, learning, and improvement.

You must check the box below to submit a report anonymously.

21 results are available.

☐ Anonymous Mode (click here to open a submission form anonymously)



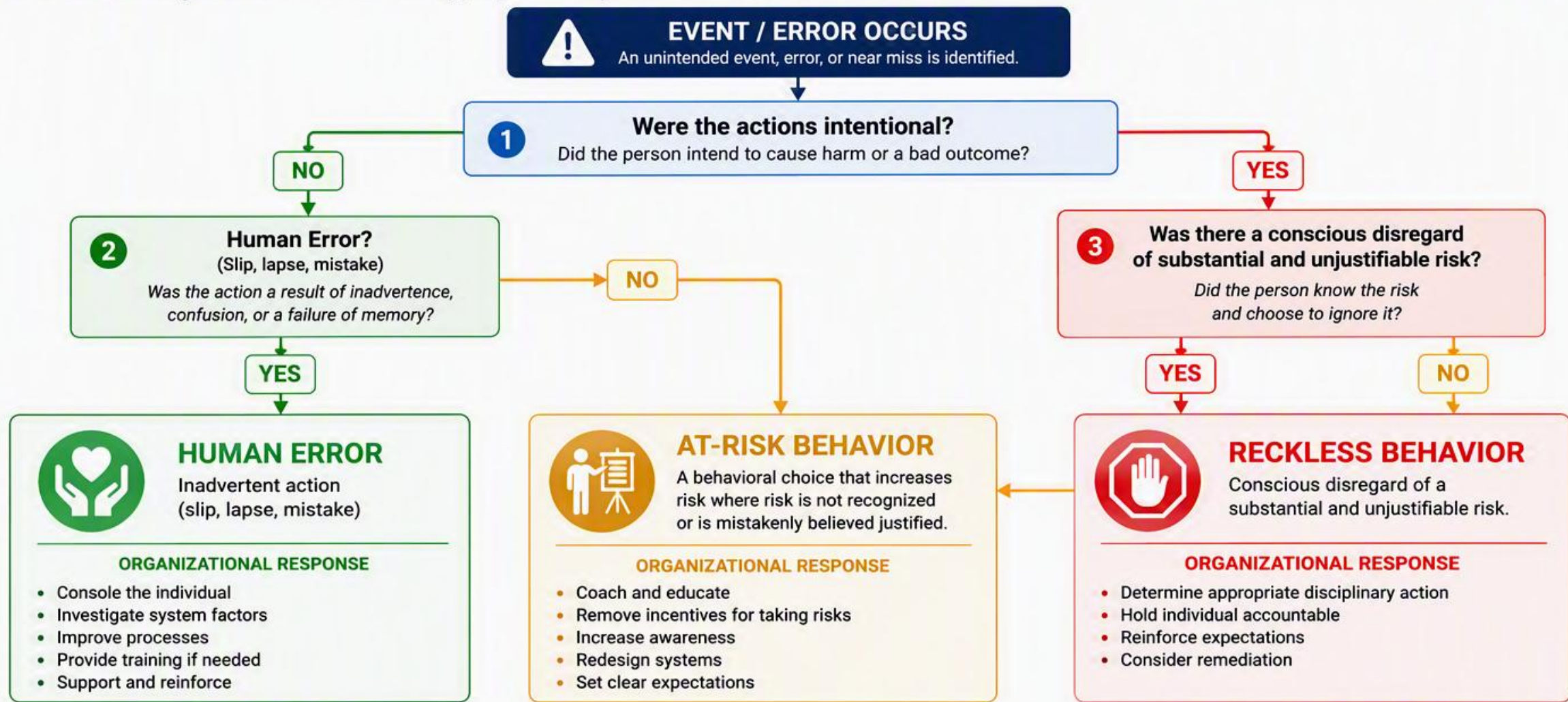
Report Sent

Now what
happens?



JUST CULTURE ALGORITHM

A decision-making tool to determine the appropriate response to an event or error.



QUICK

BEHAVIOR TYPE	DESCRIPTION	EXAMPLES	APPROPRIATE RESPONSE
 HUMAN ERROR	Inadvertent action, slip, lapse, or mistake	• Wrong medication dose due to distraction • Specimen mislabeled after being interrupted • Forgot to follow a step	Console, support, and improve system design
 AT-RISK BEHAVIOR	Behavioral choice that increases risk	• Skipping a required double-check because	



OUR GOAL



NURSES

PHYSICIANS

RISK MANAGERS

STATISTICIANS

PHARMACISTS

PSQI Team

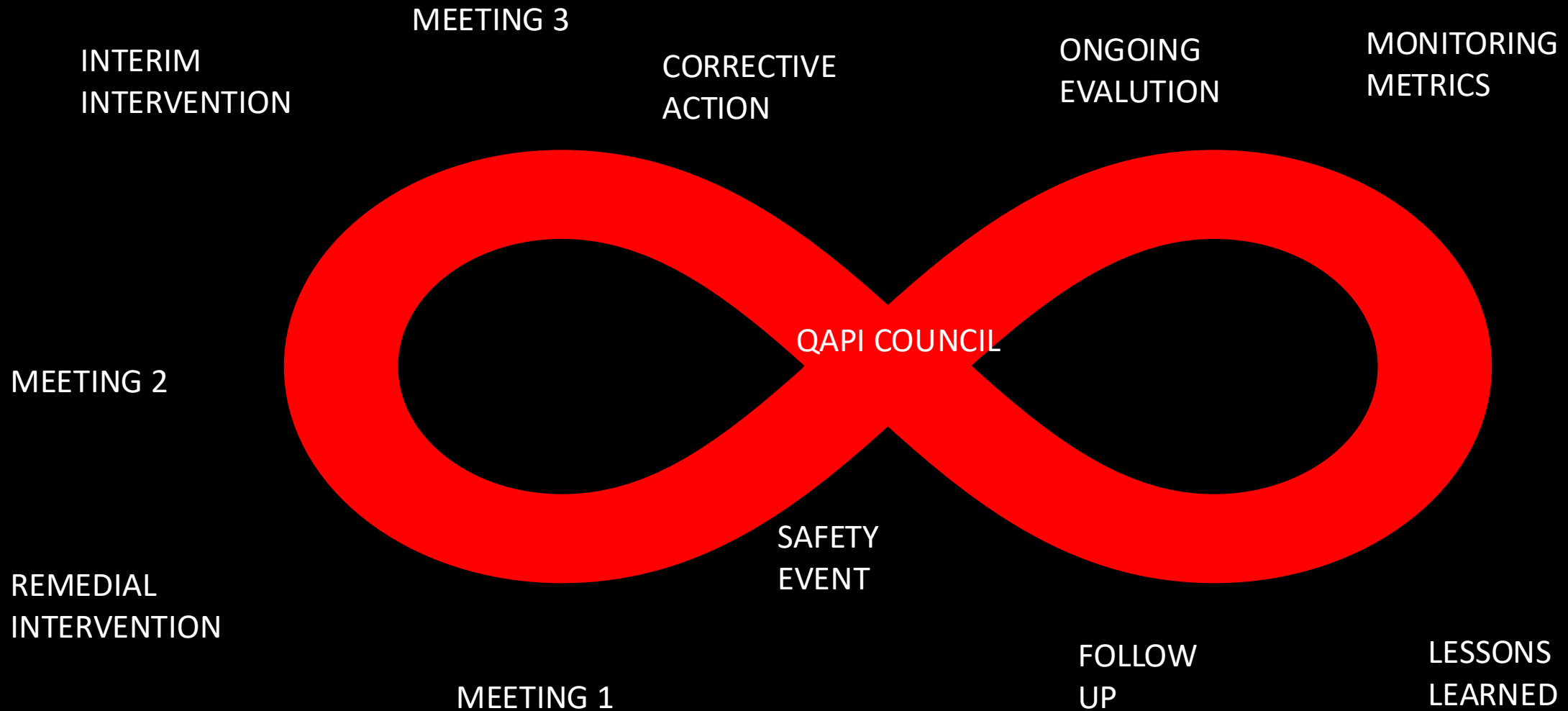
What is a quality professional?(13)

- Supporter
- Facilitator
- **Educator**
- Oversees improvement and reports results
- Could/should work in the frontlines emulating good quality practice!



Things to remember:
"Every moment is a teaching moment." (13)

Quality Assurance Performance Improvement (QAPI) CYCLE



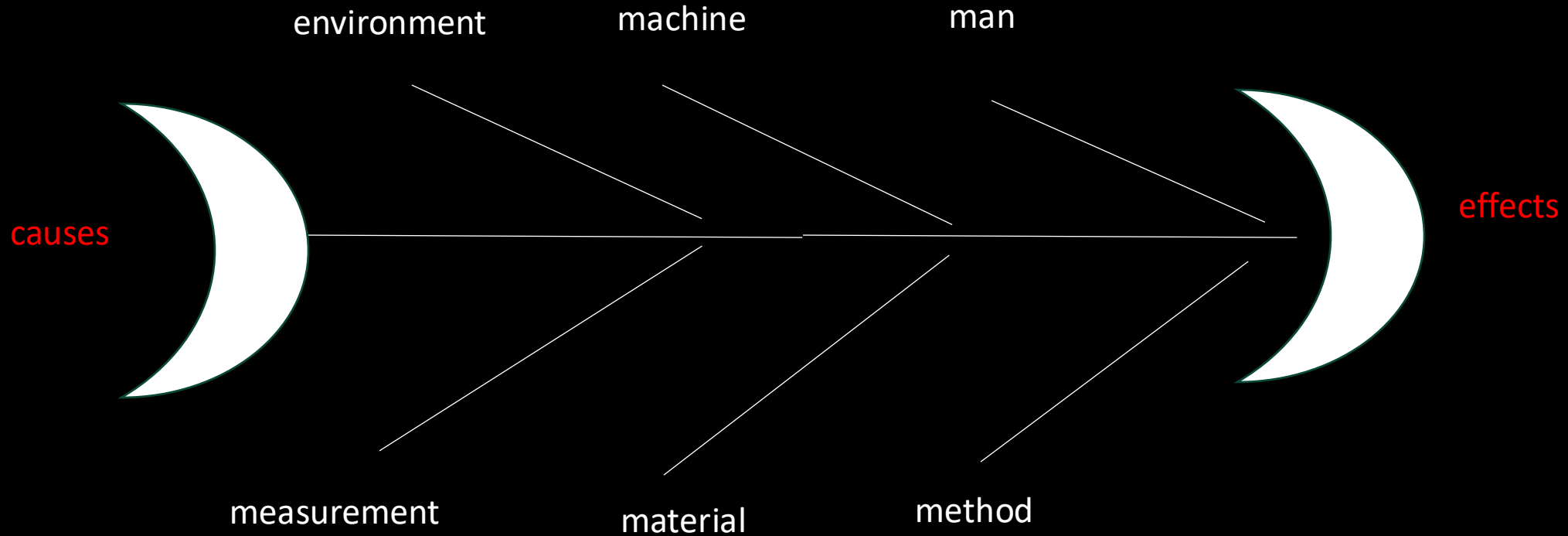
Example team function:

- Root Cause Analysis- a problem-solving event resulting in corrective action so the event ceases to occur (14)

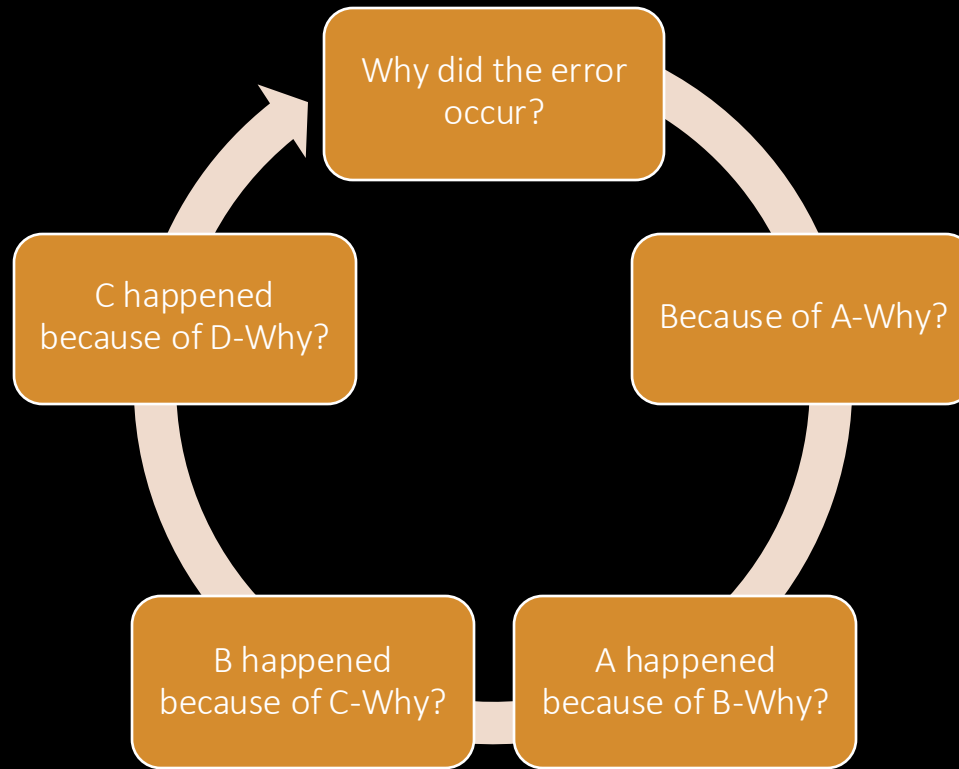
CONSIDERATIONS for Root Cause Analysis (RCA) (14)

- Define the problem.
- Identify major categories.
- Draw backbone.
- Brainstorm causes.
- Analyze group causes.
- Identify sub causes.
- Analyze relationships.

Ishikawa Fishbone Diagram (14)



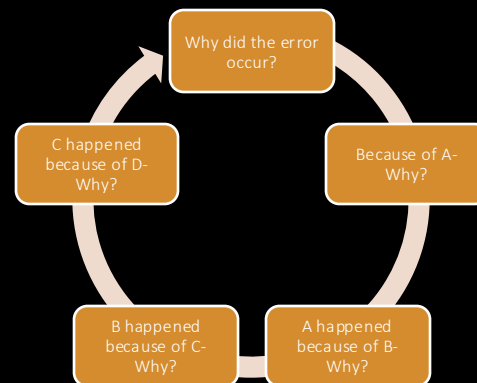
5 Whys? (14)



CASE STUDY 1

A mastectomy is accepted by the pathology laboratory with an order for an intraoperative consultation at 8:15 am labeled as right total mastectomy with patient label "ABC"

The OR schedule shows patient "ABC" is scheduled for a noon surgery and for breast reconstruction. A different patient was scheduled for the right total mastectomy. The HT accepted the specimen and confirmed receiving the correct patient in LIS. PA ordered a hard stop.



Human Factors (15)

- Human Factors are determined, coded, and the events are then reported to the institution to collect data related to the cause.
- Examples: lack of medical knowledge, physical constraints (exhaustion), reckless behavior, rushed practice, feeling psychologically unsafe

HFACS – Acts

Decision Errors

- DE001** - Caution/warning/information ignored or misinterpreted (e.g., clinical alarms)
- DE002** - Exceeded ability (i.e., competency)
- DE003** - Failure to prioritize task
- DE004** - Improper attempt to save time
- DE006** - Improper procedure performed
- DE007** - Improper remedial action
- DE008** - Improper placement/use of instrument/tools, equipment, PPE, and/or materials
- DE009** - Inadequate maintenance of equipment/supplies
- DE010** - Inadequate report provided
- DE011** - Inadequate risk assessment
- DE012** - Inadequate work pre-planning
- DE016** - Pre-procedure briefing not obtained/disregarded
- DE017** - Selected incorrect procedure
- DE018** - Use of defective instrument, equipment PPE, and/or materials
- DE020** - Wrong response to situation (e.g., failure to recognize, critical thinking failure)
- DE021** - Wrong tool/software application for the job

Perception Errors

- PE001** - Failure to hear/understand communications (e.g., due to noise)
- PE002** - Failure to identify risk/hazard
- PE003** - Misinterpreted/misread equipment
- PE004** - Misjudged the texture of a surface (e.g., slippery floor)
- PE005** - Misperceived patient factors (e.g., weight, strength, weight-bearing ability)
- PE006** - Misread displays/paperwork/text
- PE007** - Tactile distortion
- PE008** - Visual distortion

Skill-Based Errors

- SBE001** - Conducted sequence item out of order/reversed/omitted steps in procedure
- SBE002** - Data entry/cross check error (i.e., double check)
- SBE003** - Forgetting to inform team
- SBE004** - Habit transference (e.g., seen with the introduction of new equipment or procedure)
- SBE005** - Improper lifting/position for task
- SBE008** - Lapse of memory/recall for all or part of a procedure
- SBE010** - Misreading/misinterpreting paperwork or display/instrument
- SBE011** - Poor coordination or timing of action
- SBE012** - Poor technique (e.g., intubation, central line insertion, IV administration)
- SBE013** - Patient involvement in patient care process deficient
- SBE015** - Safety checklist error (e.g., universal protocol, WHO surgery checklist, double checks, medication reconciliation)
- SBE016** - Timing errors (i.e., performed task at the wrong time)
- SBE017** - Work or motion at improper speed (i.e., too fast or too slow)
- SBE019** - Lack of knowledge about delivery of supplies/care (e.g., delayed specimens, wrong care given, wrong location)
- SBE020** - Inadequate or omission of assessment of patient

Exceptional Violations

- EV001** - Delivery of care without license/qualification/privileges
- EV002** - Disabled guards, warning systems, or safety devices
- EV003** - Disruptive behavior
- EV004** - Excessive risk taking
- EV005** - Failed to secure equipment or materials properly (e.g., not putting sharps in proper container)
- EV006** - Failure to follow orders
- EV008** - Inadequate/purposeful untimely documentation/communication
- EV011** - Use of equipment/instruments/PPE/material improperly
- EV012** - Violation of policy/procedures/standard of care/training (e.g., re-consenting, provider not available)

Routine Violations

- RV001** - Delivery of care beyond the scope of practice
- RV002** - Disabled guards, warning systems, or safety devices
- RV003** - Distracting behavior
- RV004** - Exceeding duty times
- RV005** - Failed to secure equipment or materials properly (e.g., not putting sharps in proper container)
- RV006** - Failure to follow orders
- RV007** - Inadequate/untimely documentation/communication (i.e., waiting until the end of the shift to document)
- RV008** - Operation with known deficiency in equipment performed
- RV010** - Risk taking
- RV011** - Taking shortcuts (not otherwise specified) - i.e., work-arounds
- RV012** - Use of equipment/instruments/PPE/material improperly
- RV013** - Violation of written policy/procedures/standard of care/training (e.g., provider not available)

HFACS – Preconditions

Physical Environment

- PhyE001** - Clutter, debris, or slippery surfaces
- PhyE002** - Energized electrical systems
- PhyE003** - Fires or explosions
- PhyE004** - Hazardous material leak/release
- PhyE006** - Inadequate maintenance of humidity
- PhyE007** - Inadequate temperature regulation (too hot or cold)
- PhyE008** - Inadequate ventilation/air quality
- PhyE009** - Inadequate/improper workspace design (congestion or restriction)
- PhyE010** - Mechanical hazards (e.g., energized and non-energized, pump, or battery)
- PhyE011** - Noise interference (e.g., alarm overload or desensitization)
- PhyE012** - Radiation (Ionizing & Non-Ionizing)
- PhyE013** - Restricted visibility/Inadequate lighting
- PhyE014** - Natural disasters (e.g., inclement weather, such as hurricanes, tornados, or floods)
- PhyE015** - Inadequate ergonomic design/awkward position (e.g., equipment or display location)
- PhyE016** - Inadequate workplace design: control systems/displays; electrical; mechanical; structural (e.g., visibility restrictions, overhangs, or unprotected corners)

Adverse Physiological States

- APS006** - Impairment due to drugs or alcohol
- APS008** - Influences of medication
- APS010** - Medical illness/conditions (e.g., cardiac, diabetes, visual illusions, or hyperventilation)
- APS013** - Physical fatigue
- APS018** - Drowsiness

Fitness for Duty (Self-Imposed Stress)

- PR001** - Commuting irregularities (unanticipated or self induced)
- PR004** - Inadequate rest/lack of sleep
- PR009** - Physical and mental limitations due to hang-over
- PR010** - Self-Medicating while off duty
- PR011** - Unreported disqualifying medical condition
- PR012** - Use of illicit drugs and alcohol that impact fitness for duty

Technological Environment

- TechE001** - Electronic double-check process lacking effectiveness
- TechE002** - Failures of information technology (software and hardware issues)
- TechE004** - Inadequate technological design or user interface (e.g., manuals, checklists, instruments; automation; displays)
 - may lead to a workaround
- TechE009** - Unclear or confusing labels/warning signs (e.g., overrides, electronic triggers, alert fatigue)
- TechE010** - Inadequate/defective/poorly designed equipment, material, PPE, or instruments
- TechE011** - Inadequate/defective warnings/alarms
- TechE012** - Incomplete/incorrect/not current/inaccessible standard procedures
- TechE013** - No Computerized Prescriber Order Entry (CPOE)
- TechE014** - Order set inadequate for procedure or lacks critical "red flags"
- TechE016** - Unclear/outdated policies/procedures/checklists
- TechE017** - Change in/or new technology requirements (system go lives, or upgrades, missing carryover of critical functions, etc. from previous systems)

Physical/Mental Limitations

- PML001** - Body shape (e.g., incompatible height, weight, size, strength, reach, etc.)
- PML002** - Inability to sustain body positions (include repetitive movement or range)
- PML003** - Inadequate or limited experience/proficiency/practice
- PML004** - Incompatible intelligence/aptitude
- PML005** - Incompatible/temporary physical capability
- PML006** - Lacking technical procedural knowledge
- PML007** - Language barriers
- PML008** - Learning/memory ability limitations
- PML009** - Limitation due to previous injury or illness
- PML010** - Misunderstanding training instructions
- PML011** - Motor skill, coordination, or timing deficiency
- PML013** - Not current/qualified (e.g., expired license, expired certification, or lack of competency)
- PML014** - Not familiar with job, equipment, or environment
- PML016** - Pre-existing psychological/personality problems
- PML018** - Sensory deficiency (e.g., visual, hearing, touch, taste, smell, or balance)
- PML019** - Substance sensitivities or allergies

Adverse Mental States

- AMS002** - Boredom
- AMS004** - Complacency
- AMS005** - Confusion
- AMS009** - Excess mental workload/multi-tasking/task saturation/task overload
- AMS012** - Frustration
- AMS013** - Inappropriate peer pressure
- AMS014** - Inattention/Distracton
- AMS015** - Lack of confidence
- AMS017** - Mindset/preconceived idea/expectancy
- AMS018** - Misplaced motivation/inappropriate task prioritization
- AMS019** - Overaggressive/Anger
- AMS020** - Overconfidence
- AMS021** - Perceived haste/pressure to complete task
- AMS025** - Stress (job related)/mental fatigue
- AMS026** - Stress (personal)
- AMS027** - Task fixation/tunnel vision/channelized attention

Coordination/Communication/Planning Factors

- CC001** - Confusing/conflicting directions/demands by team member
- CC002** - Failed to conduct adequate briefing/pre activity planning
- CC003** - Failure of "lead" to take charge (e.g., during code blue or time-outs)
- CC004** - Failure to warn/disclose critical information
- CC005** - Inadequate/ineffective communication between teams/team members
- CC006** - Inadequate/ineffective communication between shifts/job handoff
- CC007** - Inadequate/ineffective communication of hazards (e.g., lack of plan of care or discharge planning)
- CC008** - Lack of teamwork or coordination of activities
- CC009** - Standard terminology not used or understood (e.g., lettering or abbreviations)
- CC010** - Verification techniques not used
- CC011** - Inadequate communication between team and patient/family

HFACS – Supervision

Inadequate Supervision

- IS001** - Change introduced without training or adequate training
- IS002** - Failed to provide adequate/proper tools for the job
- IS003** - Failure to track job qualifications/skills
- IS004** - Improper or insufficient delegation
- IS005** - Inadequate coaching/on the job training of skills
- IS006** - Inadequate communication of policy, procedure, practices or guidelines
- IS007** - Inadequate design of training program
- IS008** - Inadequate event reporting/investigation (e.g., lack of detail)
- IS009** - Inadequate leadership job knowledge
- IS010** - Inadequate monitoring of work (e.g., oversight of shift)
- IS011** - Inadequate new hire training
- IS012** - Inadequate or lack of safety meetings
- IS013** - Inadequate performance measurement, evaluation, and/or feedback
- IS014** - Inadequate recurrent training provided
- IS015** - Inadequate safety walk-throughs or inspections
- IS017** - Need for training not identified
- IS018** - No measurement of training effectiveness
- IS019** - Personality conflict between supervisor/manager and employee
- IS020** - Training not reinforced on the job
- IS021** - Training records incorrect
- IS022** - Inadequate Risk Assessment

Failure to Correct Known Problem

- FCP001** - Failure to correct inappropriate behavior/identify risky behavior
- FCP002** - Failure to correct known reported problem
- FCP003** - Failure to place appropriate priority on needed repairs
- FCP004** - Failure to update/revise/enforce operating guidelines, and/or policies and procedures
- FCP005** - Improper performance is rewarded or tolerated or condoned
- FCP006** - Inadequate enforcement of safe operations (e.g., hand washing, PPE, or time-outs)
- FCP007** - Inadequate health hazard evaluation (OSHA)
- FCP008** - Inadequate identification of workplace hazards

Planned Inappropriate Operations

- PIO001** - Excessive workload
- PIO002** - Failure to provide adequate work/break schedule
- PIO003** - Improper/insufficient delegation of authority
- PIO004** - Inadequate assessment of needs
- PIO005** - Inadequate equipment/safety records
- PIO006** - Inadequate hazard assessment
- PIO007** - Inadequate implementation/communication of company/departmental policy and procedures
- PIO008** - Inadequate initiating of safety review
- PIO009** - Inadequate maintenance planning/scheduling
- PIO010** - Inadequate management of change system (e.g., manual changes or work instruction changes)
- PIO011** - Inadequate safety/hazard inspection system
- PIO013** - Inadequate work turnover process (e.g., asking another healthcare professional to perform task)
- PIO014** - Job beyond capability of employee
- PIO015** - Leadership implied haste
- PIO016** - Poor matching/pairing of employees
- PIO017** - Requested employee to perform undocumented procedure

Supervisory Violations

- SV001** - Authorized unnecessary hazard
- SV002** - Authorized unqualified healthcare professional to perform task
- SV003** - Enabling excessive risk taking
- SV004** - Failure to enforce rules and regulations
- SV005** - Fraudulent documentation
- SV006** - Inadequate documentation
- SV007** - Inadequate inspection
- SV008** - Knowingly set priority of schedule over safety requirement
- SV009** - Leader encourages bending of the rules
- SV010** - Violation of operating guidelines, policy and procedures by a leader(s)
- SV011** - Willful disregard for authority by leader(s)

HFACS – Organizational Influences

Resource/Acquisition Management

- RM001** - Equipment working conditions (e.g., use of damaged or outdated supplies/materials, or the unavailability of the right tools or manuals)
- RM002** - Excessive cost cutting
- RM005** - Improper handling/storage/transport of supplies/materials
- RM006** - Improper salvage and/or waste disposal
- RM007** - Improper selection/substitution/use of supplies/materials
- RM008** - Improper/lack of training protocol (e.g., not developed)
- RM010** - Inadequate contract/vendor approval process/selection/inadequate specifications to contract/vendor
- RM012** - Inadequate facilities/equipment design
- RM013** - Inadequate identification of hazardous materials
- RM014** - Inadequate matching of qualifications for job
- RM015** - Inadequate material packaging/container
- RM016** - Inadequate monitoring of construction
- RM017** - Inadequate receiving inspection and acceptance
- RM020** - Inadequate staffing/manning procedures
- RM022** - Ineffective attrition/retention policies
- RM023** - Lack of financial reimbursement for procedure/process
- RM024** - Lack of funding
- RM025** - Lack of logistical support
- RM026** - No contractor/vendor pre-qualification/use of non-approved contract
- RM027** - Personal protective equipment not made available
- RM029** - Purchasing unsuitable equipment/parts
- RM031** - Inadequate technology/design

Organizational Processes

- OP001** - Deficient planning
- OP002** - Environmental Management process not adequately implemented/maintained
- OP003** - Failure to document change
- OP004** - Inadequate event reporting/investigation
- OP005** - Inadequate job safety analysis performed
- OP006** - Inadequate operations: operational tempo creates risk
- OP007** - Inadequate or incorrect performance feedback
- OP009** - Inadequate organizational training: not well defined or available
- OP011** - Inadequate performance measures/standards
- OP016** - Inadequate program oversight: management failed to monitor resources, climate, and processes to ensure a safe work environment
- OP017** - Inadequate strategic risk assessment
- OP019** - Lack of/inadequate established safety & quality programs/risk management programs
- OP020** - Lack of job safety analysis conducted
- OP021** - Lack of/inadequate Standard Operating Procedures (e.g., inconsistent with work processes)
- OP023** - On time performance demands/time pressures
- OP024** - Outdated Standard Operating Procedures/no revision schedule
- OP025** - Policy/standard guidelines not specific/not written
- OP034** - Unclear definition of corrective action
- OP035** - Unclear definition of objectives
- OP036** - Work/production schedules create risks

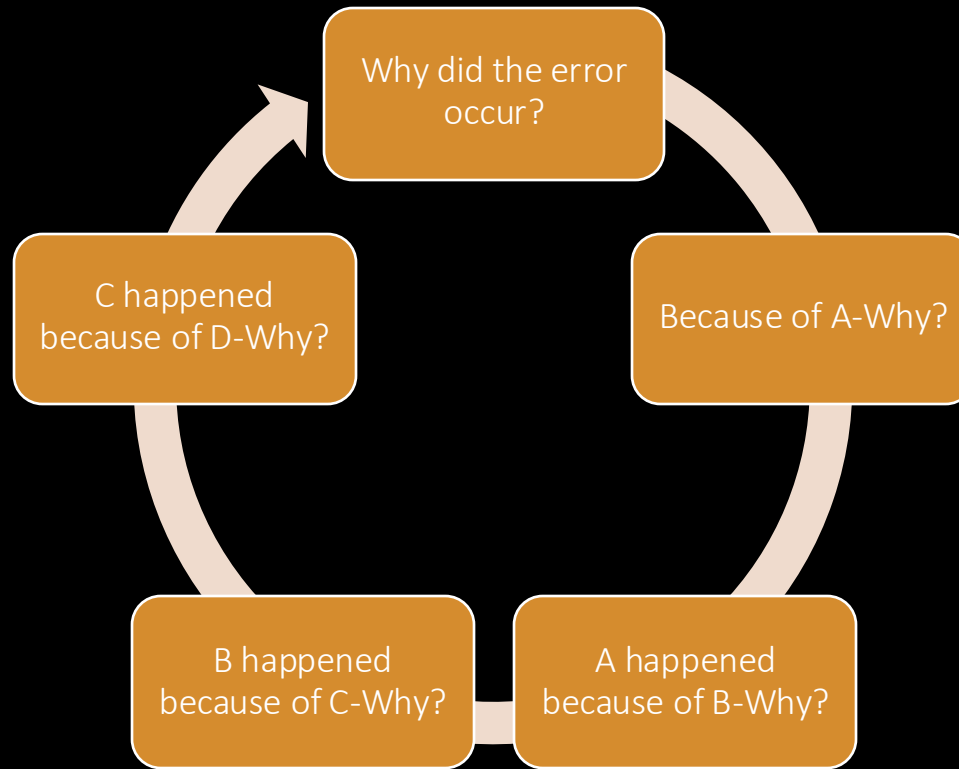
Organizational Climate

- OC001** - Employee behavior problematic
- OC002** - Policy/practices/procedures not practiced, enforced or consistent
- OC003** - Improper/insufficient delegation of authority
- OC004** - Inadequate accessibility/visibility of leadership
- OC005** - Inadequate/lack of accountability system in place (e.g., SOPs, policies & procedures)
- OC006** - Inadequate drug and alcohol policies
- OC007** - Inadequate evaluation/promotion/upgrade
- OC008** - Inadequate hiring, firing, promotion, retention
- OC009** - Inadequate event reporting, investigation, and corrective action policy and practice
- OC010** - Inadequate organizational values/culture not clearly defined/communicated
- OC011** - Inadequate organizational customs/justice
- OC013** - Inadequate organizational structure: chain of command
- OC014** - Inadequate organizational structure: communication
- OC015** - Inadequate response to employee feedback
- OC017** - Norms and rules problematic/values, beliefs, and attitudes
- OC018** - Unclear/conflicting assignment of responsibility/reporting relationships

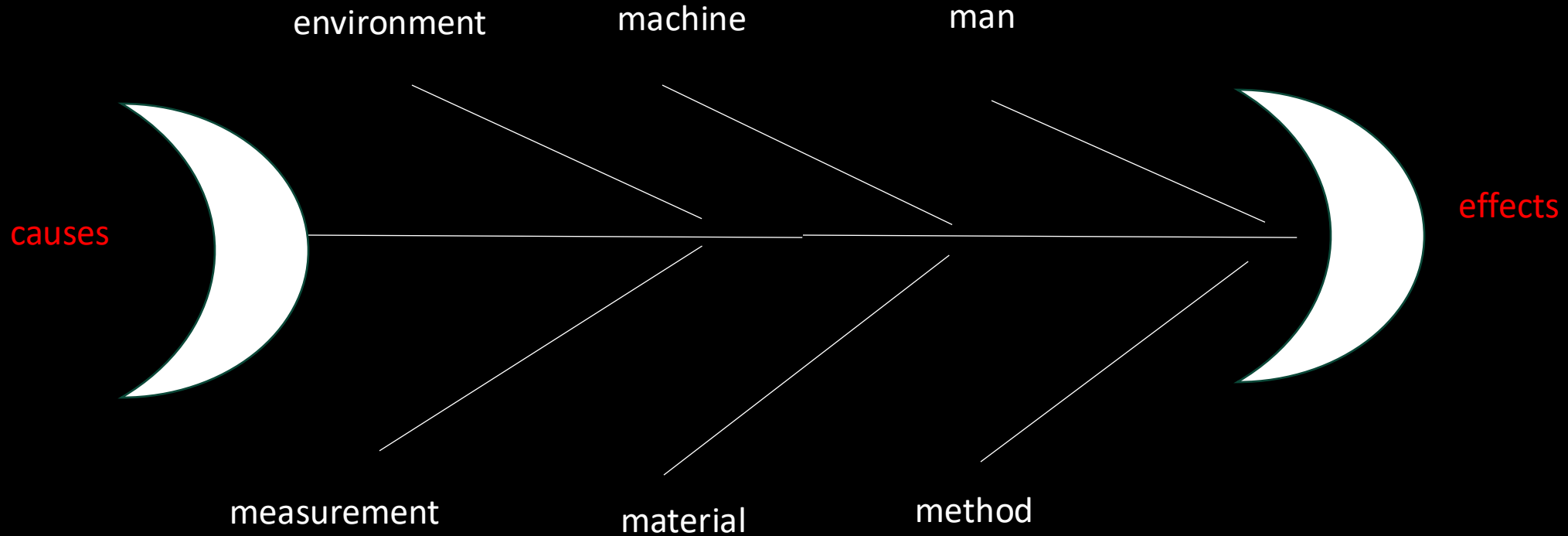
Case Study 2

There was a storm and the entire hospital building suffered power loss. The frozen lab was in darkness and without accessible LIS during an intraoperative consultation requiring the transfer of specimen radiographic images in the LIS. The lab works remotely. The pathologists and radiologists were offsite. There were no emergency lights. The power plugs installed were not linked to a backup generator.

5 Whys? (14)

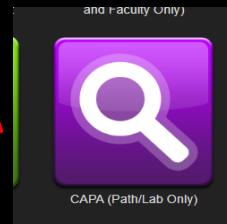


Ishikawa Fishbone Diagram (14)



What if the event happens again?

- Report again
- Report as a **CAPA**



=Corrective and Preventative Action



UT MD Anderson Clinical Safety & Effectiveness Program-Multidisciplinary Team Functions

- Classes
- Aim
- IPE
- LSSYB-proceed to LSSGB
- RCA
- Intervention
- Presentation
- Ongoing Study



APP PSQO

Works as a dyad with the divisional physician PSQO, and AP and CP
PSQO

Departmental APP Patient Safety Quality Officer

Core Focus

- Professional Practice

Evaluations (FPPE & OPPE)

Focused and Ongoing

Readiness

- Patient Safety Leadership
- Quality Improvement
- High Reliability & Just Culture
- APP Development

Key Functions & Responsibilities

- Regulatory compliance and accreditation readiness
- Develop APP competency standards
- Create and track FPPE/OPPE metrics
- Review compliance timelines
- Lead practice-changing quality initiatives
- Participate in RCA and safety investigations
- Educate and mentor APPs
- Prepare annual safety and quality reports

Early Career Opportunities

- AAPA-preceptor program, SIG for safety and management
- ASCP Leadership Academy
- CAP Inspector Training
- Educational Centers-LEADSelf and Others, Safety Reporting, Safety Report File Management, Lean Belts, CS&E Programs
- Mentorship programs
- Volunteer with strategic planning committees
- Network LinkedIn

Key Take Aways:

- Patient safety concerns are often observed in surgical pathology and PAs have a role to mitigate when they occur.

Human factors can impact patient safety and PAs can bridge that gap.

- Safety reporting involves writing the facts, and anyone can report a safety concern. **THE ARE TEACHING MOMENTS.**
- PAs can obtain leadership/PSQI competencies that align with future roles in PSQI

What do you
think?





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Thank You!



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