TITLE PAGE

Title of Project:	*Ambulatory patient safety of clients in treatment for substance abuse*
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Inclusive Dates of Project:	9/1/2007 - 8/31/2009
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FINAL REPORT:

STRUCTURED ABSTRACT (200 word limit)

Purpose: Each year in the United States, more than a million people obtain substance abuse treatment. Little if anything is known about patient safety in the context of chemical dependency treatment programs. The purpose of this project was to assess risk for clients in publicly funded outpatient substance abuse treatment.
Scope: Adult outpatient substance abuse treatment clients in a large public-sector academic health care system (Oregon Health & Science University, Portland, Oregon).
Methods: Structured interviews were conducted with all staff members addressing issues related to patient and staff safety and coordination of care.
Results: Substance abuse treatment provider responses to questions pertaining to their beliefs and experiences suggested that, though they assigned high priority to patient safety in terms of their beliefs, best practices are not always employed in the crush of day-to-day practice. In examining the pattern of correlations between items, two major themes emerged. The theme first related to perceptions of the climate in regard to patient safety. The second theme was oriented toward putting beliefs into action. **Key Words:** patient safety, standardized patients, substance abuse treatment

PURPOSE (Objectives of Study)

The objectives of the project were:
1. Draft a process map showing healthcare provision for clients entering outpatient substance abuse treatment.
2. Identify nodes in the process map where patient safety events may arise.
3. Convene health professionals involved in substance abuse treatment, including alcohol and drug abuse counselors, administrators, and support staff, and obtain feedback.
4. Update the process map based on recommendations from the health professionals.
5. Elicit from the health professionals examples of and data about patient safety events pertaining to substance abuse treatment clients.
6. Facilitate use of "walk-through" technology by the clinic director to verify the process map and identify procedural issues.
7. Measure health professionals' beliefs about organizational patient safety climate. Communicate findings to clinic staff.

SCOPE

Background, Context

Harm to patients from provision of healthcare is a substantial problem. In its report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine (2000) estimated that, in 1999, as many as 98,000 people may have died owing to injuries received in hospitals. Consequently, there have been numerous calls for improvements in healthcare delivery in order to ensure patient safety. It is reasonable to assume that outpatients may also be at risk of harm from the healthcare system. For example, there is evidence suggesting that prescription medication errors presumably occurring among outpatients may be responsible for over a thousand deaths each year (Phillips and Bredder, 2002). Hence, there is value in addressing ambulatory patient safety issues, including those pertaining to people in outpatient treatment for chemical dependency.

Settings

The project was conducted at Oregon Health & Science University, which is a publicly funded healthcare provider organization. Located in Portland, the University is Oregon's only academic health center. Among many other services, the University provides ambulatory care to individuals with substance abuse conditions. Data for this study were collected from the Behavioral Health Clinic, a state-certified provider of substance abuse treatment services that has been in operation for over 50 years.[1]

Participants

Participants consisted of all staff members at an ambulatory adult substance abuse treatment clinic. Most respondents were White (85%). Other ethnic backgrounds included African American (5%), Asian (5%), and Native Hawaiian or other Pacific Islander (5%). Ages ranged from 23 to 66 (M = 42, SD = 15), and the majority were women (63%). Education levels varied from associate's degrees to MD/PhD, with the majority reporting a master's degree (68%).

Incidence and Prevalence

Not applicable. Incidence and prevalence rates have not been examined for this population.

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[1] Over these 50 years, the clinic has gone through two name changes. Originally, it was known as the Alcoholism Treatment and Training Center. Currently, it is called the Avel Gordly Center, reflecting a broader mission with a greater focus on minority populations. These changes were unrelated to this study.

METHODS

Study Design

Qualitative data were gathered through semi-structured interviews. Preliminary interviews were conducted with intake and clinical personnel to develop a process map for clients entering the program. This process map and themes from the interviews were presented to clinic staff and feedback for refinements was solicited. Information gathered through these channels was used to inform interview guides for structured interviews with all clinic personnel. A list of general themes was developed from the transcriptions of the interviews. Randomly selected clinician, administrator, and prescriber (MD) transcripts helped the research team further refine these themes into a coding list (see Appendix). General themes were summarized into a coding scheme for use with the Atlas.ti computer software program for qualitative research and qualitative data analysis. This program allows researchers to analyze common themes across transcripts. The research team was particularly interested in differences in clinicians' versus administrators' perspectives, as their training and preparation for working with this patient population are quite dissimilar.

Based on the process map, a "walk-through" was conducted. The clinic director portrayed a client entering the treatment system. Researchers observed interactions between the client/director and clinic staff.

Qualitative data were supplemented with survey data addressing prevalence of errors, disclosure of errors (to patients, to other staff members, as documentation in the chart), responses to errors, knowledge of the Patient Safety Net, and reporting errors to various entities as well as patient safety related attitudes and beliefs.

Data Sources/Collection

Participants were treatment counselors and administrative staff at the Behavioral Health Clinic (Oregon Health & Science University), an ambulatory adult substance abuse treatment clinic. Clients at this clinic have numerous problems associated with chemical dependency and co-occurring mental health and physical conditions.

Interventions

Not applicable. This project was not an intervention study. However, the project provides information pertinent to future studies and improved interventions for substance abuse treatment clients.

Measures

Staff attitudes regarding patient safety and medical fallibility were assessed through a self-report instrument modified from Madigosky, Headrick, Nelson, Cox, and Anderson's (2006) questionnaire and semi-structured interviews. Attitudinal items were supplemented with behaviorally oriented questions based on themes identified in that study. Item wording and content for all survey questions are shown in the results section.

Limitations

Because the study was a planning project, the scope was intentionally limited. The chief focus was on one substance abuse treatment agency, which is part of one healthcare provider organization. The project was not able to examine in any detail services (and patient safety events) outside the scope of the study healthcare provider organization. However, the methods developed in this planning grant can subsequently be applied to work involving other organizations.

The walk-through was conducted by the clinic director portraying a client. Staff were asked to regard the walk-through as an exercise and to treat the clinic director as a new client. Of course, it may well have been difficult for staff to regard the director in this role. Nonetheless, this exercise provided important data that can be used for future work, possibly involving standardized patients (actors) trained to portray new substance abuse treatment clients.

Another deliberate limitation was the focus on the first or identification stage in patient safety improvement (Battles and Lilford, 2003). Building on a presentation by the late John Eisenberg, Battles and Lilford (2003) described three stages regarding research pertaining to patient safety. The first stage is the identification of "risks and hazards that cause or have the potential to cause healthcare-associated injury or harm." The second stage is to "design, implement, and evaluate patient safety practices that eliminate known hazards, reduce the risk of injury to patients, and create a positive safety culture." The third stage is to "maintain vigilance to ensure that a safe environment continues and patient safety cultures remain in place." Because the study was innovative, the emphasis was on the first or identification stage (Battles and Kanki, 2004). Later projects will be able to make use of the findings of this study to address the design and implementation of patient safety practices pertaining to ambulatory substance abuse treatment.

RESULTS

Principal Findings

Qualitative data were collected in the form of a walk-through by the clinic director (observed by researchers) and interviews with all staff members at a substance abuse treatment clinic (N = 22). Content from interview transcripts was used to develop a list of general themes. A summary of recurring themes with potential consequences for patient safety is listed below. Review of randomly selected clinician, administrator and prescriber (MD) transcripts helped the research team further refine these themes into a coding list (see Appendix) for use with Atlas.ti.

Primary themes identified through interview data included workload, differing perspectives between clinical and administrative staff, advantages and disadvantages of paper versus electronic charting, concerns about staff training, coordination of care, patient and staff safety, reporting adverse events and errors, and responses to errors. These results are discussed in more detail in the next section.

Outcomes, Discussion

Walk-through

The walk-through revealed several areas of potential concern. It began at the front desk when the director/client checked in. There seemed to be some confusion at the front desk regarding what information a client was expected to know prior to meeting with the counselor (e.g., which counselor he/she would be seeing) and who should accept and process the initial paperwork. Clearly, inappropriately routed paperwork could have repercussions for patient safety if crucial information does not reach the counselor in a timely manner. It was unclear whether the receptionist's confusion should be attributed to lack of knowledge, to anxiety arising from the evaluative context inherent in a director's walk-through, or both. The clinician also appeared to be disconcerted when asked to treat the director as a new client and seemed to have some difficulty behaving naturally. Nevertheless, the researchers observed behaviors that were unlikely to be a response to an unnatural situation that could (a) adversely affect confidentiality and (b) raise barriers to effective client/counselor communication.

Confidentiality: Client files were open on the counselor's desk when the "client" was brought into the office. Although this oversight may not be typical, use of paper charts, heavy workloads and limited time for charting may enhance the likelihood of such an error occurring.

Communication: The furniture arrangement in the office forced the counselor to turn away from the client during the behavioral health assessment – a situation exacerbated by long periods of silence while the counselor completed the (somewhat extensive) assessment form. Clearly, this arrangement could make it more difficult to establish the rapport necessary to encourage clients to reveal uncomfortable information about themselves.

Interview Themes

Workload:

Both clinical and administrative personnel consistently cite heavy workloads as a potential cause for concern. In order for the clinic to remain financially viable, staff members are required to maintain very high levels of productivity. Staff members sometimes have difficulty balancing the need for providing high-quality services with high-productivity demands. Staffing difficulties in the form of high turnover over an extended period of time have intensified these difficulties. Stringent (and varied) reporting requirements can be burdensome.

Differing Perspectives:

Clinical and administrative staff frequently espouse very different perspectives as they face competing demands. Communication is sometimes inconsistent, fragmented, or (unintentionally) unclear. Lack of training due to high staff turnover often exacerbates the problem. Logistical constraints such as physical locations of charts sometimes make it difficult for different functional areas to interface smoothly. However, both clinical and administrative staff are deeply committed to providing high-quality services to clients.

Charting:

The current paper-based charting system offers advantages in terms of privacy and familiarity but also creates inefficiencies. Charts are kept on a different floor due to space constraints, making access more difficult for staff members. This situation has led to some challenges in keeping charts up to date. Reactions to electronic medical records as an alternative are mixed among clinical staff. There are concerns about training issues, confidentiality, and expense. Administrative staff feel electronic medical records would greatly facilitate more efficient record keeping, but they are also concerned about the expense.

Training:

Administrative staff feel under-trained for crisis management. Clinical staff expressed fewer concerns in this area. Heavy workloads sometimes make it difficult to provide training opportunities for interns and new employees.

Coordination of Care:

Overall, most staff members across functional areas seem to feel that coordination of care and communication between treatment providers are not major concerns.

Patient and Staff Safety:

There are several aspects of the physical environment that are less than ideal from a safety perspective (e.g., no back exit, no panic buttons in counselors' offices, front desk is highly accessible and provides limited protection against aggressive clients) The bathroom key was attached to a heavy wrench to keep it from "walking away" that also could be used as a weapon.

Reporting Adverse Events and Errors:

Results of the survey data indicate that there is some confusion about event reporting requirements (a copy of the survey is included in the Appendix). Currently, there is very little agreement regarding what kinds of events staff are required to report (see Table 1). With the exceptions of temporary minor events and near misses (in which the majority of respondents indicated they are not required to report error events), about half the staff said yes and half said no to reporting each type of event. Furthermore, slightly over half the staff reported they did not know which kinds of events should be reported in general. Clarification of reporting requirements (all levels are actually required to be reported) among staff members is desirable.

Table 1. *Event Reporting Requirements**

	No		Yes	
	n	%	n	%
Required to report serious event	8	42	11	58
Required to report major permanent event	10	53	9	47
Required to report major temporary event	11	58	8	42
Required to report minor permanent event	11	58	8	42
Required to report minor temporary event	13	68	6	32
Required to report near miss	14	74	5	26
Don't know what required to report	9	47	10	53

  *Definitions of each type of error are available in the Appendix

Responses to Errors, Number of Errors, and Knowledge of Patient Safety Net:

Another section of the survey asked respondents about actions they took or witnessed in response to errors (Table 2). The patterns of answers in combination with the inconsistencies observed in the knowledge of reporting requirements seem to suggest an informal approach to error events. This finding is not meant to imply that errors are not viewed as important. In fact, a relatively small percentage (11%) reported that no action was taken in response to an error (equivalent to the number of cases that led to disciplinary action against a staff member). In fact, the most common actions taken in response to an error event involved reviewing and possibly changing policies and procedures (47% reviewed, 32% changed). This finding may indicate that the clinic favors responses that are less focused on the individual or the specific event (i.e., a systems-oriented approach). However, the lack of consistency in knowledge of reporting requirements may represent a different dynamic. It is possible that individuals feel more comfortable reporting errors that are more readily attributed to policies and procedures, but errors that are more clearly due to a lapse on the part of the staff member may be less frequently brought to the attention of others.

Table 2. *Actions Taken in Response to Errors*

	No		Yes	
	n	%	N	%
Log entry for in-house database	19	100	0	0
Initiated own investigation	18	95	1	5
Referred information for investigation	19	100	0	0
Policies reviewed	10	53	9	47
Procedures reviewed	10	53	9	47
Policies changed	13	68	6	32
Procedures changed	13	68	6	32
Staff education	16	84	3	16
Staff disciplined	17	89	2	11
Staff reported to licensing board	19	100	0	0
No action taken	16	89	2	11
No errors observed	14	74	5	26

Approximately half the staff members had never seen an error event or near miss (Table 3). Among those who had seen an error or near miss, witnessing more than one event was most common, although witnessing three or more events was rare. Thematic summaries of errors and near misses are as follows:

- Inadequate communication between clinic staff and police resulting in additional distress for client during police intervention.
- Communication difficulties between clinic and pharmacy (e.g., prescriptions not called in, wrong prescription, client not provided with information about potential side effects of a medication).
- Errors in judgment on the part of counselors in the course of treatment.
- Scheduling conflicts or financial constraints resulting in less than optimal treatment.
- Poorly handled crisis calls.

Table 3. *Number of Errors and Near Misses Witnessed by Staff Members*

	n	%
0	8	50
1	2	13
2	4	25
3	1	6
More than 3	1	6

The Patient Safety Net program is the Oregon Health & Science University web-based reporting system of "anything that happens or could happen to harm patients & visitors or present a risk of harm." Despite being mandated, the system was not well known in this population (Table 4). Of the 19 staff members surveyed, only five (26%) had heard of the Patient Safety Net. None of the staff members had any further knowledge of the program (i.e., visited the website, spoken to someone from the organization, attended a meeting, or received training).

Table 4*. Knowledge of Patient Safety Net*

	No		Yes	
	n	%	N	%
Never heard of the Patient Safety Net	5	26	14	74
Have heard the name	15	79	4	21
Visited the website	19	100	0	0
Spoken with someone from Patient Safety Net	19	100	0	0
Attended a meeting about Patient Safety Net	19	100	0	0
Received training about Patient Safety Net	19	100	0	0

Self-Disclosing Errors and Near Misses:

Staff members were also asked how likely they were to disclose making an error that resulted in harm to the patient. Seriousness of harm varied from a minor temporary injury or near miss to an injury that would permanently compromise the person's ability to perform the tasks involved in daily living. Staff members were asked to indicate how likely they were to disclose the mistake to the patient, a peer, or a supervisor; document it in the chart; or notify risk management personnel or the Patient Safety Net. Results are shown in Tables 5 through 10.

With the exception of reporting mistakes to risk management personnel, staff members indicated they were least likely to disclose committing an error through any channel when the error resulted in a minor, temporary injury.

Conversely, staff members were most likely to communicate an error when the mistake resulted in serious consequences or permanent injury. Interestingly, an almost opposite pattern emerged for reporting mistakes to risk managers. Staff members were most inclined to report a major temporary injury and least likely to disclose a major permanent injury. Near misses were less likely to be communicated to any source.

Table 5. *Self-Disclosing a Serious Event*

If you committed an error resulting in serious event for the client. Would you:	Absolutely		Probably		Probably Not		Absolutely Not	
	n	%	n	%	n	%	n	%
Disclose to the client?	14	74	5	26	0	0	0	0
Disclose to a peer?	9	47	8	42	2	11	0	0
Disclose to a supervisor?	17	89	1	5	1	5	0	0
Be concerned about being disciplined?	11	61	6	33	1	6	0	0
Document the event in the chart?	17	89	1	5	1	5	0	0
Notify risk management?	8	47	5	29	4	24	0	0
Notify the Patient Safety Net?	5	29	5	12	5	29	0	0

Table 6. *Self-Disclosing a Major Permanent Error*

If you committed an error resulting in major permanent issue for the client. Would you:	Absolutely		Probably		Probably Not		Absolutely Not	
	n	%	n	%	n	%	n	%
Disclose to the client?	13	72	5	28	2	11	0	0
Disclose to a peer?	10	56	6	33	0	0	0	0
Disclose to a supervisor?	17	94	1	6	0	0	0	0
Be concerned about being disciplined?	11	65	6	35	0	0	0	0
Document the event in the chart?	14	78	3	17	1	6	0	0
Notify risk management?	8	50	5	31	3	19	0	0
Notify the Patient Safety Net?	5	33	4	27	5	33	0	0

Table 7. *Self-Disclosing a Major Temporary Error*

If you committed an error resulting in major temporary issue for the client. Would you:	Absolutely		Probably		Probably Not		Absolutely Not	
	n	%	n	%	n	%	n	%
Disclose to the client?	11	61	6	33	1	6	0	0
Disclose to a peer?	8	44	7	39	3	17	0	0
Disclose to a supervisor?	14	78	3	17	1	6	0	0
Be concerned about being disciplined?	9	53	7	41	1	6	0	0
Document the event in the chart?	14	78	2	11	2	11	0	0
Notify risk management?	7	44	4	25	5	31	0	0
Notify the Patient Safety Net?	4	27	5	33	5	33	0	0

Table 8. *Self-Disclosing a Minor Permanent Error*

If you committed an error resulting in minor permanent issue for the client. Would you:	Absolutely		Probably		Probably Not		Absolutely Not	
	n	%	n	%	n	%	n	%
Disclose to the client?	11	61	6	33	1	6	0	0
Disclose to a peer?	8	44	7	39	2	11	1	6
Disclose to a supervisor?	14	78	4	22	0	0	0	0
Be concerned about being disciplined?	5	29	11	65	1	6	0	0
Document the event in the chart?	13	72	2	11	3	17	0	0
Notify risk management?	7	44	5	31	4	25	0	0
Notify the Patient Safety Net?	5	33	4	27	5	33	0	0

Table 9. *Self-Disclosing a Minor Temporary Error*

If you committed an error resulting in minor temporary issue for the client. Would you:	Absolutely		Probably		Probably Not		Absolutely Not	
	n	%	n	%	n	%	n	%
Disclose to the client?	11	58	5	26	3	16	0	0
Disclose to a peer?	5	26	8	42	5	26	1	5
Disclose to a supervisor?	15	79	1	5	3	16	0	0
Be concerned about being disciplined?	6	33	5	28	7	39	0	0
Document the event in the chart?	13	68	2	11	4	21	0	0
Notify risk management?	9	53	2	12	6	35	0	0
Notify the Patient Safety Net?	5	31	3	19	7	44	1	6

Table 10. *Self-Disclosing a Near Miss*

If you committed an error resulting in a near miss for the client. Would you:	Absolutely		Probably		Probably Not		Absolutely Not	
	n	%	N	%	n	%	n	%
Disclose to the client?	3	16	7	37	7	37	0	0
Disclose to a peer?	1	5	9	47	8	42	0	0
Disclose to a supervisor?	12	63	5	26	1	5	0	0
Be concerned about being disciplined?	4	21	5	26	10	53	0	0
Document the event in the chart?	8	42	7	37	4	21	0	0
Notify risk management?	5	29	4	24	8	47	0	0
Notify the Patient Safety Net?	2	13	3	19	10	63	0	0
Do nothing if no negative outcomes for client.	2	11	2	11	11	58	2	11

Overall, participants' responses to questions pertaining to their beliefs and experiences suggested that, although they assigned a high priority to patient safety in terms of their beliefs, best practices are not always employed in day-to-day practice (Table 11). Moreover, responses suggest that, though participants believe that sharing information about errors is important, discussion of and reporting of actual errors are less common than might be expected. Furthermore, with 63% of respondents indicating that they "strongly agreed" or "agreed" with the statement "After an error occurs, an effective strategy is to work harder to be more careful," systems-wide approaches would seem to be under-utilized. This discrepancy may be due in part to perceptions that the substance abuse treatment culture provides limited support for dealing constructively with errors.

Table 11. *Attitudes and Beliefs Relating to Patient Safety Issues*

	Mean	SD	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Clinicians should not tolerate uncertainty in patient care	3.21	1.18	5%	53%	11%	21%	11%
Making errors in substance abuse treatment is inevitable	3.37	1.12	16%	32%	32%	16%	5%
Clinicians should routinely spend part of their professional time working to improve patient care	4.68	0.58	74%	21%	5%	0%	0%
In my clinical experience staff communicate to me that patient safety is a high priority	3.79	1.08	32%	32%	21%	16%	0%
The culture of substance abuse treatment makes it easy for providers to deal constructively with errors	2.53	0.90	0%	16%	32%	42%	11%
Learning how to improve patient safety is an appropriate use of time	4.53	0.61	58%	37%	5%	0%	0%
If I saw a patient safety error, I would keep it to myself	1.68	0.95	0%	5%	16%	21%	58%
If there is no harm to a patient, there is no need to address an error	1.84	1.01	5%	0%	11%	42%	42%
Clinicians routinely report patient safety errors	2.58	1.07	5%	11%	37%	32%	16%
There is a gap between what we know as "best care" and what we provide on a day to day basis	3.83	0.86	22%	44%	28%	6%	0%
Only clinicians can determine the causes of a patient safety error	2.16	0.60	0%	0%	26%	63%	11%
Most errors are due to things that clinicians can't do anything about	2.37	0.60	0%	5%	26%	68%	0%
After an error occurs, an effective strategy is to work harder to be more careful	3.84	0.76	21%	42%	37%	0%	0%
Clinicians routinely share information about errors and what caused them	2.84	1.12	11%	16%	26%	42%	5%
Reporting systems do little to reduce future errors	2.53	0.77	0%	11%	37%	47%	5%
Competent clinicians do not make patient safety errors that lead to patient harm	2.37	0.83	5%	5%	11%	79%	0%

Conclusions

Analysis of qualitative and quantitative data produced several surprises, as some of the sources that might be expected to be problematic (e.g., patient deception, coordination of care across providers and across clinics) did not emerge as concerns. Conversely, the project was able to identify some constraints that could adversely affect patient safety from unexpected sources. The most prevalent themes focused on workload, logistical constraints, physical limitations imposed by the environment, communication, and unclear reporting requirements for clinical errors.

The issue raised most often was workload. Although staff members routinely reported high levels of commitment, this clinic, like most substance abuse treatment agencies, faces difficult challenges in balancing financial viability with service excellence. The combination of high productivity, time-intensive reporting obligations, and scarce resources creates a demanding work environment for both clinical and administrative personnel. Use of an electronic (rather than paper) medical record might alleviate some inefficiencies within the system, but, at least for now, cost poses an insurmountable barrier. Concerns about privacy, training (including time to train), and ease of use would also need to be considered before implementing a new record-keeping system.

Marked differences in the perspectives of clinical and administrative personnel represented one of the more interesting findings in this study.

Unfortunately, these differences have at times led to ineffective communication and friction between functional areas. One area in need of special attention is training in crisis management. Although most clinical personnel felt adequately trained for handling volatile and potentially dangerous clients, administrative staff often reported feeling ill prepared and vulnerable.

Participants also reported several issues with the physical environment that could complicate maintaining a safe environment for patients and staff. For example, the building has no back exit, which creates difficulties for intimate partner violence clients needing a private exit in case a perpetrator comes to the clinic. Participants also mentioned that the accessibility of the front desk can make it difficult for staff members working in that area to protect themselves from aggressive or volatile clients. Because these physical issues are difficult to address once a clinic is established within a particular location, substance abuse treatment clinics may need to consider some rather subtle aspects of the physical environment from a safety perspective when choosing a facility.

Finally, although clinic staff consistently endorsed items, indicating that they consider patient safety a high priority, there were discrepancies between espoused beliefs and self-reported behavior when it came to discussing errors with colleagues or reporting errors in the chart, to the clinic, or to regulatory agencies. These discrepancies may be due in part to perceptions that the substance abuse treatment culture in general provides little support for dealing constructively with errors as well as concerns about harsh judgments from colleagues should an error be revealed. Moreover, there seems to be some confusion about which kinds of errors need to be reported and limited knowledge about the Patient Safety Net. Taken together, these results suggest that communication around safety issues may be more fragmented than is apparent to staff members and managers at the clinic.

Significance

Organizational work related to chemical dependency pertains in large measure to factors that facilitate or impede the implementation of evidence-based treatments. Extensive literature review found few (actually no) papers specifically addressing impact of organizational factors on patient safety issues of the type described here in the context of outpatient substance abuse treatment. Although there is growing understanding about ways to improve patient safety (Battles, 2006a; Battles, 2006b), this work has yet to be applied to programs serving outpatient substance abuse treatment clients. This project expanded knowledge on this topic by focusing on outpatient substance abuse treatment patients in a large urban healthcare system.

Implications

The planning grant project addressed risk assessment for outpatient substance abuse treatment clients. The project sets the stage for patient safety interventions useful for substance abuse treatment clients. These considerations are important because more than a million people in the United States obtain substance abuse treatment each year, chiefly in outpatient programs. This planning grant study generated information needed to design future projects that could employ standardized patient methodology to improve substance abuse patient safety. The anticipated benefit will be groundbreaking work with regard to substance abuse treatment patient safety. The work completed in this study sets the stage for subsequent interventions designed to eliminate or minimize patient safety risks for clients in ambulatory substance abuse treatment programs.

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LIST OF PUBLICATIONS AND PRODUCTS (Bibliography of Published Works and Electronic Resources <u>from Study</u>)

Patient safety and outpatient substance abuse treatment clients (Lewy C, Oliver C, Bianconi J, McFarland B). Abstract in preparation for the American Psychiatric Association annual meeting.

APPENDIX:

Dear Behavioral Health Clinic Employee:

Thank you for agreeing to take part in this study. All of your answers are anonymous. Please remember that there are two boxes, one for the first page of the survey containing information about who you are, and the second box for the rest of the survey. That way, we can't link any personal information to your other responses about patient safety. If you have any questions, please let us know (503-418-3768). Questionnaires are due:_____

The following definitions are helpful for the first few questions.

Definitions:

Medical Error: Any mistake in the delivery of care, by any healthcare professional, regardless of outcome.

Serious Event: An objective and definable consequence of patient care, that is unanticipated, may be preventable, and results in: Life-threatening consequences or death; Loss of a body part; Hospitalization or prolonged hospitalization; Disability or loss of bodily function that last for more than seven days; Cancer; Congenital anomaly; or Other significant morbidity, including significant physical or psychological injury to the patient.

Major Permanent Error: A permanent injury that affects basic functions of daily living; these are Serious Events.

Major Temporary Error: A temporary injury that exceeds Minor Temporary or increases length of hospitalization by one to six days.

Minor Permanent Error: A permanent injury that does not compromise basic functions of daily living.

Minor Temporary Error: Minor patient injury, increased patient monitoring, or change in treatment plan.

Near Miss: An error that could have led to a Serious Event or Major Error but did not due to planned or unplanned actions.

1. Suppose you commit a medical error that results in a **Serious Event** to the patient:

	Absolutely	**Probably**	**Probably Not**	**Absolutely Not**
Would you tell the patient?				
Would you tell a peer?				
Would you tell a supervisor?				
Would you be concerned about being disciplined?				
Would you document event in the chart?				
Notify risk management/clinical risk/quality management?				
Notify the patient safety net?				

2. Suppose you commit a medical error that results in a **Major Permanent Error** to the patient?

	Absolutely	**Probably**	**Probably Not**	**Absolutely Not**
Would you tell the patient?				
Would you tell a peer?				
Would you tell a supervisor?				
Would you be concerned about being disciplined?				
Would you document event in the chart?				
Notify risk management/clinical risk/quality management?				
Notify the patient safety net?				

3. Suppose you commit a medical error that results in a **Major Temporary Error** to the patient?

	Absolutely	Probably	Probably Not	Absolutely Not
Would you tell the patient?				
Would you tell a peer?				
Would you tell a supervisor?				
Would you be concerned about being disciplined?				
Would you document event in the chart?				
Notify risk management/clinical risk/quality management?				
Notify the patient safety net?				

4. Suppose you commit a medical error that results in a **Minor Permanent Error** to the patient?

	Absolutely	Probably	Probably Not	Absolutely Not
Would you tell the patient?				
Would you tell a peer?				
Would you tell a supervisor?				
Would you be concerned about being disciplined?				
Would you document event in the chart?				
Notify risk management/clinical risk/quality management?				
Notify the patient safety net?				

5. Suppose you commit a medical error that results in a **Minor Temporary Error** to the patient?

	Absolutely	Probably	Probably Not	Absolutely Not
Would you tell the patient?				
Would you tell a peer?				
Would you tell a supervisor?				
Would you be concerned about being disciplined?				
Would you document event in the chart?				
Notify risk management/clinical risk/quality management?				
Notify the patient safety net?				

6. Suppose you commit a medical error that results in a **Near Miss** to the patient?

	Absolutely	Probably	Probably Not	Absolutely Not
Would you tell the patient?				
Would you tell a peer?				
Would you tell a supervisor?				
Would you be concerned about being disciplined?				
Would you document event in the chart?				
Notify risk management/clinical risk/quality management?				
Notify the patient safety net?				

7. What level of events are you required to report to an outside authority like a supervisor? (circle all that apply)

Near Miss   Minor, temporary event   Minor, permanent event

Major, temporary event   Major, permanent event   Serious event

I don't know

8. How many errors or near misses have you seen at your clinic?
    0 (no errors or near misses)
    1
    2
    3
    More than 3

Please describe the error(s) or near misses:

_____
_____
_____

9. As a result of a medical error or near miss, have you ever observed any of the following at your clinic? (circle all that apply)

    Event entered into an in-house database
    Investigated event on your own
    Referred event information to another agency or in-house program for investigation
    Seen policies reviewed
    Seen procedures reviewed
    Seen a change in policies
    Seen a change in procedures
    Staff Education
    Staff Discipline
    Staff referred to licensing board
    Other:_____
    There were no actions

    There haven't been any errors or near misses.

10. What if anything have you heard about the Patient Safety Net? (circle all that apply)
    I've never heard of it.
    I've heard the name.
    I've seen the website.
    I've talked to someone from the Patient Safety Net
    I've attended a meeting about it.
    I've received training about it.

Indicate how much you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Clinicians should not tolerate uncertainty in patient care					
Making errors in substance abuse treatment is inevitable.					
Clinicians should routinely spend part of their professional time working to improve patient care.					
In my clinical experience staff communicate to me that patient safety is a high priority.					
The culture of substance abuse treatment makes it easy for providers to deal constructively with errors.					
Learning how to improve patient safety is an appropriate use of time.					
If I saw a patient safety error, I would keep it to myself.					
If there is no harm to a patient, there is no need to address an error.					
Clinicians routinely report patient safety errors.					
There is a gap between what we know as "best care" and what we provide on a day-to-day basis.					
Only clinicians can determine the causes of a patient safety error.					
Most errors are due to things that clinicians can't do anything about.					
After an error occurs, an effective strategy is to work harder to be more careful.					
Clinicians routinely share information about errors and what caused them.					
Reporting systems do little to reduce future errors.					
Competent clinicians do not make patient safety errors that lead to patient harm.					

Code List

Code Name	Description
Administrative Concerns	Perceived problems with existing administrative processes and procedures.
Assessments	Clinical or administrative assessments.
Barriers	Comments related to problems or struggles with other codes.
Change	Reactions to the pace of change, and the amount of change in the clinic, including the steep learning curves involved in introducing new software and procedures.
Charts	Existing issues and explanations of charting. Excludes discussions of electronic medical records (use EMR code instead).
Clinic System	Comments pertaining to the clinic as a system. Usually, more specifics are provided (e.g., who oversees whom and when, who contacts who in an emergency)
Confidentiality	Comments or concerns about possible loss of client or staff confidentiality, including processes and procedures used by the clinic to protect confidentiality.
Conflict	Interpersonal conflict or concerns/discontent with interaction patterns among clinic personnel.
Consent	Issues related to obtaining patient consent for procedures within the clinic or sharing information outside the clinic.
Coordination of Care: External	Sharing of patient information between clinics/sources of care
Coordination of Care: Internal	Division of responsibility for patient care within the clinic (time, medication management, particular treatment modalities).
Counselor of the Day	Any reference to counselor of the day procedures.
Diversity	Comments relating to ethnic/racial/gender differences among patients or clinic personnel (psychiatrists, admin staff, clinicians).
Documentation	General discussions relating to documentation within the clinic. Assessment discussions are coded separately.
EMRs (electronic medical records)	Discussion of issues relating to EMRs, including value, problems/concerns, desire for or against. Includes respondent's understanding of whether or not they have an electronic medical record at the time of the interview.
Facilitating Factors	Things that are working well or could be improved to support more effective functioning within the clinic.
Improvements Desired	Comments about what the respondent would like to see improved.
Job History	Historical context for the current clinic employee.
Job Role	The respondent's duties, tasks, responsibilities, time allocation, etc.
Monitoring Patients	Supervision and general monitoring of patients (medication management, treatment plan adherence).
Organizational Influences	Comments about people, money, grants, political activities, etc. that influence the clinic at any level (organizational structure, clinical, financial).
Patient Compliance	Discussion can range from compliance with medication, treatment plans, appointment times, paperwork requirements, etc.
Patient Deception	Specific references to patients' lying or inadvertently misinforming staff at the clinic (e.g., about medications, background).
Patient Preparation	Comments related to what patients are equipped with (e.g., paperwork,

Code Name	Description
	stories, knowledge of diagnosis) when seeing any member of the staff.
Patient Profile	Classes of patients (e.g., co-occurring disorders, DUI, self-referred, gamblers, Byrne grant).
Prescribing	Specific discussions of how prescribing operates in the clinic.
Quality Control	How the clinic ensures quality of procedures (charts, clinical interventions, physical needs).
Reason for Patient Visit	Discussions centering on why a patient saw the clinic staff member (regardless of job role). This includes referral sources.
Safety	Comments pertaining to patient or staff safety.
Suicide	Discussion of how the clinic or individuals handle situations of possible or actual suicide.
Time Efficiency	Issues related to time wasting, conserving, or changing allocation of time (e.g., travel to and from another floor to obtain charts).
Violent or Volatile Clients	Recognition and description of violent or volatile clients. Description of how the clinic and/or individuals in the clinic handle these clients.
Work Load	Issues relating to staff work load, including the impact on any aspect of clinic functioning.
Workforce Development	Topics related to moving the workforce forward (trainings, increased supervision) including issues related to workforce development progress (hiring problems, high turnover).