Creating a Culture of Safety

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MedStar Health
MedStar Health

- Mid-Atlantic Region
- Large Healthcare System
- Ten hospitals
- Medicaid Managed Care Organization
- Center for Human Factors Engineering in Healthcare
- Research Institute
- Home Health Agency
- 150 Outpatient sites of care
- 26,000 Associates
- 6,700 Physicians
- 162,000 Inpatient Admissions
- 762,000 Inpatient Days
- 1,492,000 Outpatient Visits
- 215,000 Home Health Visits
Creating a Culture of Safety

Educate the Young…
Creating a Culture of Safety

Educate the Young…
and Regulate the Old
Healthcare’s Triple Aim

• Strong Leadership Commitment
• Transparency
• Patient Engagement
• Interprofessional Teamwork
• Reporting Everything
• Measuring Everything
• Organizational Respect and Support
Creating a Culture of Safety

• High Reliability
• Transparency
• Patient-Centered, Patient-Engaged, Patient-Driven
• Just Culture
• Respect for fellow workers
Creating a Culture of Safety

• High Reliability
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High-reliability organizations, or HROs, share two essential characteristics:
1. They constantly confront the unexpected
2. They operate with remarkable consistency and effectiveness
Improving crew attitudes and competencies in error management

Initial attitudes, awareness and competencies

Poor leadership skills
Ineffective communication
Stress management
Poor teamwork

Mishap
Improving crew attitudes and competencies in error management

- Initial Attitudes
- Altered Attitudes
  - Increased Awareness
  - Proficiency tools
- Simulators;
  - Line operations safety audit (LOSA)
- Decreased Mishaps
Improving medical attitudes and competencies in error management

- Initial Attitudes
- Altered Attitudes
- Simulators; Line operations safety audit (LOSA)
- Increased Awareness
- Proficiency tools
- Improved Patient care
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The five habits of highly reliable organizations:

1. Don't be tricked by your success (Preoccupation with Failure)
2. Defer to your experts on the front line (Deference to Expertise)
3. Let the unexpected circumstances provide your solution (Commitment to Resilience)
4. Embrace complexity (Reluctance to Simplify)
5. Anticipate -- but also anticipate your limits (Sensitivity to Operations)
Figure 1. The five specific concepts that help create the state of **mindfulness** needed for reliability, which in turn is a prerequisite for safety.

From AHRQ “Becoming a High Reliability Organization: Operational Advice for Hospital Leaders”
Collective Mindfulness

Goals of mindful practice:

• To become more aware of one’s own mental processes, listen more attentively, become flexible, recognize bias and judgments, and thereby act with principles and compassion.
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The Ongoing Quality Improvement Journey: Next Stop, High Reliability
Mark Chassin and Jerod Loeb
Health Affairs, 30, no.4 (2011):559-568

• Leadership
• Safety Culture
• Robust Process Improvement
Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average

- SSEs per 10,000 Adj. Patient Days
- Fiscal Year Goals (FY07=0.75 / FY08=0.50 / FY09=0.20)
- Baseline [1.0 (FY05-06)]
- Threshold for Significant Change

** Each point reflects the previous 12 months. Threshold line denotes significant difference from baseline for those 12 months (p=0.05).
** The narrowing thresholds in FY2005-FY2007 reflect increasing census. Adjusted patient days for FY07 were 27% higher than for FY05.

- aSSERT Began July 2006

Chart Updated Through 30 Sep 09 by Bob Carpenter, Legal Dept.

Source: Legal Dept.
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For more information on High Reliability

*Educate the Young* blog --
[www.educatetheyoung.wordpress.com](http://www.educatetheyoung.wordpress.com)
Creating a Culture of Safety

- High Reliability
- Transparency
"You should've seen the look on our faces when we realized that we'd been looking at the x-rays backward for the first hour of surgery."
Definition of Professionalism

AAMC & NBME:

- Altruism
- Honor and Integrity
- Caring and Compassion
- Respect
- Responsibility
- Accountability
- Excellence and Scholarship
- Leadership
Definition of Professionalism

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Creating a Culture of Safety

• High Reliability
• Transparent
  – Transparency in Reporting
Creating a Culture of Safety

• High Reliability
• Transparent
  – Transparency in Reporting
  – Transparency in Outcomes
Creating a Culture of Safety

- High Reliability
- **Transparent**
  - Transparency in Reporting
  - Transparency in Outcomes
  - Transparency in Communications
    - Informed consent/Shared-decision making
    - Disclosure after harm
National Recognition of the “Seven Pillars” Program

News Release

FOR IMMEDIATE RELEASE
Friday, June 11, 2010

Contact: HHS Press Office: (202) 690-6343
AHRQ Public Affairs: (301) 427-1855

HHS Announces Patient Safety and Medical Liability Demonstration Projects

Funds Allocated to Develop, Implement, and Evaluate Patient Safety Approaches and Medical Liability Reform Models

Largest federal investment connecting medical liability to quality
National Recognition of the “Seven Pillars” Program

Navigating the Health Care System
Advice Columns from Dr. Carolyn Clancy

AHRQ Director Carolyn Clancy, M.D., has prepared brief, easy-to-understand advice columns for consumers to help navigate the health care system. They will address important issues such as how to recognize high-quality health care, how to be an informed health care consumer, and how to choose a hospital, doctor, and health plan. Check back regularly for new columns.

Dr. Clancy, a general internist and researcher, is an expert in engaging consumers in their health care.

Select for Previous Columns.

Revealing Medical Errors Helps Chicago Hospitals Build a Safer Health System

The Seven Pillars process works because it spells out and follows steps that we know make a lasting difference in building a safer health system. Reporting, communicating, creating a culture of learning, and other improvements move us closer to identifying and fixing patient safety gaps, rather than simply assigning blame.
Creating a Culture of Safety

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• High Reliability
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  – Dana Farber
  – Virginia Mason
  – Cincinnati Children’s Hospital
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• Just Culture
UNSAFE ACTS ALGORITHM

Were the actions as intended? NO
Evidence of illness or substance use? NO
Knowingly violated safe procedures? NO
Pass substitution test? (Could someone else have done the same thing)? YES
History of unsafe acts? YES

Were the consequences as intended? NO
Known medical condition? YES
Were procedures available, workable, intelligible, correct and routinely used? NO
Deficiencies in training, selection, or inexperienced? NO
Blameless error

YES
Blameless error, corrective training, counseling indicated

NO
Possible reckless violation

YES
System induced violation

NO
Possible negligent behavior

Possible substance abuse without mitigation
Sabotage, malevolent damage
Substance use with mitigation

Culpable
Gray Area
Blameless

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- Respect for fellow workers
Paul O’Neill on Safety

Every worker’s experience, every day:

- I am treated with **respect** by everyone else, regardless of position, education or pay

- I have the education and training, the tools, and the **support** to develop to my full potential

- My work is noticed and **appreciated**
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CODE OF CONDUCT OBJECTIVE:
UIMC strives to maintain a work environment free from intimidating, demeaning, abusive or disruptive behavior. These behaviors undermine a healthy work environment that supports patient safety and teamwork.
Number and Percentage of Attending Physician Disruptive Behavior Reports by Category
October 2010 - March 2011

- Failure to support UIMC mission, values and patient rights: 22/70 = 31%
- Foul Language or Loud Vocalization: 14/70 = 20%
- Unwilling to Listen: 10/70 = 14%
- Failure to maintain a safe environment: 10/70 = 14%
- Temper Tantrum: 8/70 = 11%
- Inappropriate Body Language: 1/70 = 1.4%
- Violent and Abusive Behavior: 1/70 = 1.4%
- Victimization: 1/70 = 1.4%
- Patient Confidentiality: 1 case are pending review

Unwilling to Listen
Failure to support UIMC mission, values and patient rights
Foul Language or Loud Vocalization
Failure to maintain a safe environment
Temper Tantrum
Inappropriate Body Language
Violent and Abusive Behavior
Victimization
Patient Confidentiality
Number and Percentage of Attending Physician Disruptive Behavior Reports by Department
October 2010 - March 2011

- Surgery: 6/23 = 26%
- Neurosurgery: 3/23 = 13%
- Anesthesia: 2/23 = 9%
- Medicine: 2/23 = 9%
- Plastic Surgery: 2/23 = 9%
- Vascular: 2/23 = 9%
- ENT: 2/23 = 9%
- Ophthalmology: 2/23 = 9%
- Orthopedics: 2/23 = 9%
- Psychiatry: 2/23 = 9%
- Radiation Oncology: 2/23 = 9%
- Urology: 2/23 = 9%
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Humiliation

The *emotional* response of people (individuals, families, nations, and other groups) to their perception that another person or group has unfairly or unjustly lowered, debased, degraded, or brought them down to an inferior position, that they are not receiving the respect and dignity they believe they deserve.
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Humiliation

Sense of powerlessness; “power gradient” in place

Wide variation among people in their response to the trauma of humiliation and their ability to either grow from or be damaged by the experience
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1. Think about a time when you were humiliated and how you felt when it happened.
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1. Think about a time when you were humiliated and how you felt when it happened.

2. Think about a time when you saw one caregiver humiliate another caregiver and how you felt when it happened.
Creating a Culture of Safety

1. Think about a time when you were humiliated and how you felt when it happened.

2. Think about a time when you saw one caregiver humiliate another caregiver and how you felt when it happened.

3. Think about a time when you saw an open, honest and professional discussion between caregivers and how you felt when it happened.
Eighth Annual Roundtable:
“The Power of Change Agents: Teaching Caregivers Effective Communication Skills to Overcome the Multiple Barriers to Patient Safety and Transparency”
June 25th – June 28th, 2012
Telluride, CO

Sponsored by TDCF, MedStar Health and UIC IPSE
Telluride Roundtable Vision

To create an annual retreat where stakeholders in patient safety, patient advocacy and health science education come together in a relaxed and informal setting to discuss, develop and refine curricula that support a culture of patient safety, transparency and optimal outcomes in health care.
Telluride Roundtable Vision

“Teaching Open, Honest and Professional Communication Skills to Overcome the Multiple Barriers to Transparency"
Telluride Patient Safety Student and Resident Summer Camps

Telluride Summer Camp Goals

**Patient Safety Student Summer Camp learning objectives:**

By the end of the Summer Camp, students will be able to:

1. Describe at least three reasons why open, honest and professional communication between caregivers, patients and family members is critical to patient safety, transparency and reducing harm in healthcare.
Telluride Summer Camp Goals

Patient Safety Student Summer Camp learning objectives:

By the end of the Summer Camp, students will be able to:

2. Utilize tools and strategies to lead change specific to improving communication and reducing patient harm.
Telluride Summer Camp Goals

Patient Safety Student Summer Camp learning objectives:
By the end of the Summer Camp, students will be able to:

3. Implement, lead and successfully complete a Safety/QI project at their institution over the next twelve months.
Leading Change  
John Kotter

1) Establish a sense of urgency
2) Create the guiding coalition
3) Develop a vision and strategy
4) Communicate the changing vision
5) Empower broad-based action
6) Generate short-term wins
7) Consolidate gains and produce more change
8) Anchor new approaches in the culture
The Faces of Medical Error…from tears to transparency:
The Story of Lewis Blackman

www.transparentlearning.com

Knowledge and Compassion Focused on You

CONFIDENTIAL - For Peer Review Purposes Only – Not For Distribution
Telluride Blogs

• Transparent Health -- Telluride
  www.transparenthealth.wordpress.com

•
  http://runningahospital.blogspot.com/2012/06/telluride-patient-safety-camp-day-1.html
Telluride Reflections

Almost all medicals students acknowledged that the four days they spent on patient safety education at the Telluride Summer Camp was more training than they get in their four years of medical school. While all schools have some training in patient safety, it is still infrequent and rarely longitudinal.
Telluride Reflections

“I don’t think that I've ever thought so much about informed consent as I did today. A discussion about informed consent to the level of detail that we had today needs to be part of all residency training in the first days of orientation and as refresher training later on in training. All physicians can, and should, do much better in providing informed consent.”
Telluride Reflections

“Our discussion on the roles of nurses at different institutions was eye-opening in the sense that many of my peer medical students had very little knowledge about other allied health professionals.”
Telluride Reflections

“The discussion about nursing and doctoring reminded me of conversations I had with fellow classmates at school. We were studying for the NBME Behavioral Sciences exam and joking about the ethical dilemma practice questions we were working on. A common theme that we noticed is that any answer involving soliciting a nurse for help or consulting with a nurse would invariably be wrong…”
Telluride Reflections

…We agreed that answers involving nurses can be crossed off and it would be nice to get one on the test because we could narrow down the answers easier. Almost like how there used to rarely be positive depictions of minorities in the cinema, early medical education is nearly void of positive depictions of nurses.”
Telluride Summer Camp

http://www.youtube.com/watch?v=FrA4GxCWgjw&feature=player_embedded

Jordan Chanler-Berat