Patient Safety:
Getting Sustainable Improvement

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Objectives

- Define Goal
- Identify Challenges
- Discuss Tools and Approaches to Achieve Goals to Evolve into a High Reliability Organization
  - Examples
- Identify the Role that Leaders at All Levels Must Play to Make a Culture of Safety Integral to the Fabric of the Organization

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Definitions

- Culture
- Quality – The extent to which a service or product produces a desired outcome(s).
- Safety – Prevention or moderation of hazard induced harm.
- Hazard – A circumstance or agent that can lead to harm, damage, or loss.
- Risk – The chance of a specific event occurring. Measured in terms of consequences and likelihood.

"If you don't know where you are going, any road will take you there"

Lewis Carroll

GOAL

No patient will be inadvertently harmed while under our care

Prevention

Prevention
Not Punishment

Where Healthcare Was/Is

- Cottage Industry Mentality
- Virtually Total Reliance on:
  - Professional/Individual Responsibility
  - Individual Perfection
  - Train and Blame
- Little Understanding of Systems Relative to People and Processes

Culturally Different!!!!

Typical Approach

- New Policies, Regulations,Reporting Systems, Training
- Good First Step But…..
  - Lack of Systems Insight
  - Superficial Solutions (?Answers)
  - Inadequate Follow-Up
  - Lost Opportunity

Unenlightened Institutional Risk Management

- What is its primary goal?
  - Prevent fiscal loss
    - or
  - Prevent harm to patient
- Reactive or Proactive?
- Proactive approaches are oriented towards primary prevention instead of the more common secondary prevention or absence of any preventive approach

Systems-Based Approach

- Preventive Approach
- Consider Not Only Proximate Causes **BUT** Also Underlying Contributing Causes
- Influence Providers Behavior – Individually and Organizationally
- Concrete, Actionable, & Observable Actions
- Viewed by the Target Audience as Useful

High Reliability Organization (HRO)

- Preoccupation With Failure
- Reluctance to Simplify – root causes not just proximate causes
- Sensitivity to Operations – frontline perspective
- Resilience – anticipate failure and readily improvise solutions
- Deference to Expertise – merit of argument versus who makes argument

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Identify the Problem

Awareness and Shame May Be the Largest Hurdles

- Survey at VHA and Data From Other Private Healthcare Organizations
  - Only 27% Agreed that Errors were a Serious Problem
  - 49% "Ashamed" by Error
- IOM report concurs

Combating Shame: Blameworthy Concept

- Safety Reports Are Only For Systems Improvement
- Reports Kept Confidential/Nonpunitive As Long As **Not** Deemed 'Intentionally Unsafe'
  - Criminal Act
  - Under Influence of Alcohol or Illicit Drugs
  - Purposely Unsafe
- Supervisory System Is A Parallel Process
  - May Not Use Identified Info From Safety Report

Patient Centered

"The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, union of forces is necessary."
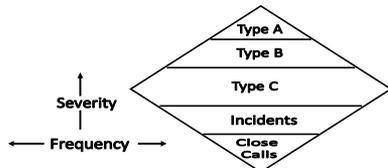
William J. Mayo
1910

Patient Safety System Design

- High Reliability Organizations
- Role of Reporting
  - Learning, **NOT** Accountability
- Systems-Based Solutions
  - Patient Centered – DUH!!!!
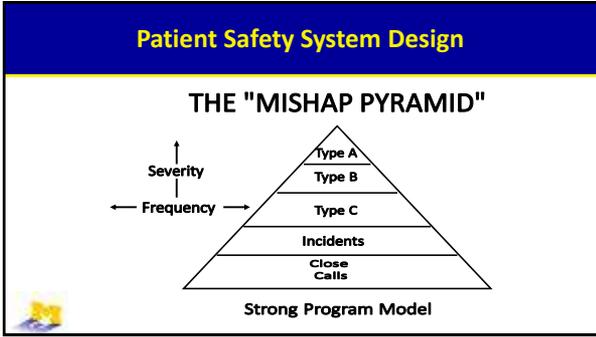- Importance of Close Calls

Patient Safety System Design

THE "MISHAP DIAMOND"

Type A
Type B
Type C
Incidents
Close Calls

↑ Severity

← Frequency →

Weak Program Model

Patient Safety System Design

THE "MISHAP PYRAMID"

Severity ↑

← Frequency →

Type A
Type B
Type C
Incidents
Close Calls

Strong Program Model

Program Elements

- Goal – Prevent Inadvertent Harm To Patient While Under Our Care
- Culture Not Compliance
- Identify Barriers
- Reporting Systems
  - **Learning, Not Accountability**
  - **Identify Vulnerabilities, Not for Counting**
  - *Transparency, Meaningful Feedback, Resulting Actions*
- Systems-Based Solutions

Risk-Based Prioritization

Prioritization

- Risk-Based, **NOT SOLELY SEVERITY BASED**
  - Severity
  - Probability
- Must Make Sense
  - Business Processes
  - Regulatory Environment

Safety Assessment Code (SAC)

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Identifying Root Cause/Contributing Factors

Safety & Human Error: Cornerstones

- People Don't Come to Work to Hurt Someone or Make a Mistake
- Must Keep Asking "Why?"

Causation/Actions: Who vs. What & Why

- Who
  - 'Whose Fault Is This?'
  - Actions focused on correcting individual
  - 'Corrects' only after problem occurs
  - Limited scope of action and generalizability
- What & Why
  - Actions focus on systems level causation
  - Widespread applicability
  - Stronger preventive strategy

Systematic
(5 Rules of Causation)

- Cause and Effect
- ⭐ • Human Error Must Have Preceding Cause
- ⭐ • Failure to Follow Procedure By Itself Is **NOT** a Root Cause
- Negative Descriptors Aren't Actionable
- Failure To Act Is **Not** A Cause Without Pre-existing Requirement To Act

Why,Why,Why,Why,Why,Why……..

Strength of Actions

Human Factors Engineering and "Actions"

- **Warnings and labels** (watch out!)

- **Training** (don't do that)

- **Procedure changes** (work around that)

- **Interlock, lock-in, lock-out, etc** (design it so you

  cannot do that – forcing functions)

- **Is there one right action**???

Weaker

Stronger

Action Hierarchy

Less memory or reliance on individual performance	**Stronger Actions**	Architectural/physical plant changes New devices with usability testing before purchasing Engineering control or interlock (forcing functions) Simplify the process and remove unnecessary steps Standardize on equipment or process Tangible involvement and action by leadership in support of patient safety
	Intermediate Actions	Redundancy Increase in staffing/decrease in workload Software enhancements/modifications Education using simulation-based learning with a competency assessment completed on a recurring basis Eliminate/reduce distractions (sterile medical environment) Checklist/cognitive aid Eliminate look and sound-alikes Repeat-back/Read-back Enhanced documentation/communication
Greater reliance on memory and individual performance	**Weaker Actions**	Double checks Warnings and labels New procedure/memorandum/policy Traditional training Additional study/analysis

Implementation

Getting to Sustainable Improvement

- Problem Identification
- Clear Goal Definition
- Involvement Of All Sectors/Stakeholders
- Identify Systems Influences
- Identify Systems Controls
- Identify Constraints
- *Critique – Go To Worst Critics Early On*
- Pilot – Volunteers First Then Others
- Evaluate

http://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx

NPSF National Patient Safety Foundation

Essential Elements For Sustainable Success
- Appropriate Goal Identification & Selection
- Transparent & Explicit Risk-Based Prioritization
- Blameworthy NOT Blame Free Or Punitive
- Identification of Real Causes & Contributing Factors
- System-Based Actions That Address Underlying Causes
- Stronger Actions That Are Explicit
- Measurement of Actions
  - Process & Outcome
- Top Leadership Involvement/Visibility
  Leadership by EXAMPLE

Leadership -
What Can Be Done Right Now?

- *Lead by Example*
- Relentless Drumbeat
- Eliminate 'Whose fault is it?'
- Encourage Skepticism
  – Devil's Advocate is Valued
- Distinguish **Real** Priorities From Official Priorities
- Part of Every Agenda
- *What Happened?, What Should Have Happened?, What Usually Happens?*

Leadership & Boards

- Leadership support <u>critical</u> to success
  – Who?
    - CEO and Board
  – What?
    - Approval of actions
    - Rationale for actions not approved
      - Transparent Acceptance of Risk
    - Determining organization-wide applicability
  – How?
    - Be cognizant of "Red Flags" (e.g., 5 Rules of Causation)
    - Assess actions against Hierarchy

Leadership - Key Points

- Transparent Risk-Based Prioritization Methodology
- Emphasize Systems-Based Solutions
  – Determination of Real Underlying Causes
  – Seek Out Stronger Solutions
- Emphasize Formal Scrutiny of Close-Calls
- *Interventions Must Go Farther Than Simply Training and Policy*

There is no shame in failing while attempting to achieve a worthy goal, the only shame is in not attempting to achieve a worthy goal.