TriHealth

# Team Collaboration with Patient Safety & Error Reporting

David Dhanraj, MD, MBA
Becky Williams, MEd

# Finding From First CLER Report (2012)

**"Overall, the residents were inconsistent in their awareness and understanding of the hospital's system for reporting patient safety concerns including:**

1) **what type of events should be reported,**
2) **who was responsible for reporting,**
3) **what mechanism should be used to report. Of those interviewed, only a few residents had any direct experience filing a report using the hospital's online (Quantros) system. In general, they seemed to defer to the nurses to file the reports."**

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# Addressing the CLER Finding

- Forming the Team
  - GME Leadership
  - Program Faculty
  - Residents

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# Addressing the CLER Finding

- Forming the Team
  - GME Leadership
  - Program Faculty
  - Residents
  - Patient Safety
  - Performance Improvement
  - Quality Assurance
  - Research

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# Addressing the CLER Finding

- Forming the Team
- **Resident Alignment**
  - Awareness of institution initiatives
  - Assessment of resident knowledge and attitudes

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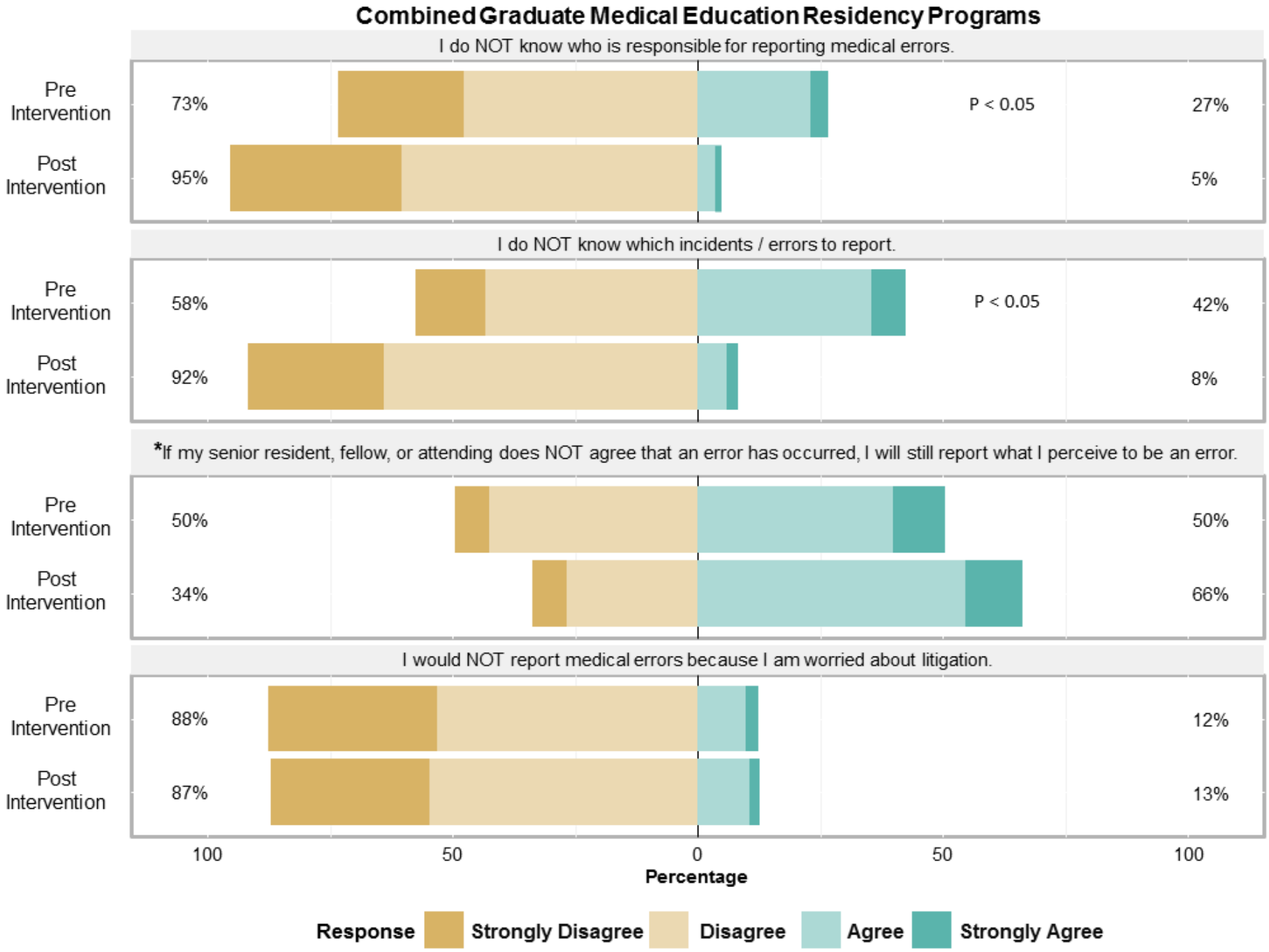
Combined Graduate Medical Education Residency Programs
I do NOT know who is responsible for reporting medical errors.
Pre Intervention
Post Intervention
73%
95%
P < 0.05
27%
5%
I do NOT know which incidents / errors to report.
Pre Intervention
Post Intervention
58%
92%
P < 0.05
42%
8%
*If my senior resident, fellow, or attending does NOT agree that an error has occurred, I will still report what I perceive to be an error.
Pre Intervention
Post Intervention
50%
34%
50%
66%
I would NOT report medical errors because I am worried about litigation.
Pre Intervention
Post Intervention
88%
87%
12%
13%
100
50
0
50
100
Percentage
Response
Strongly Disagree
Disagree
Agree
Strongly Agree

# Addressing the CLER Finding

- Forming the Team
- Resident Alignment
- **Education on the Reporting System**
  - Program specific
  - Reporting system demonstration

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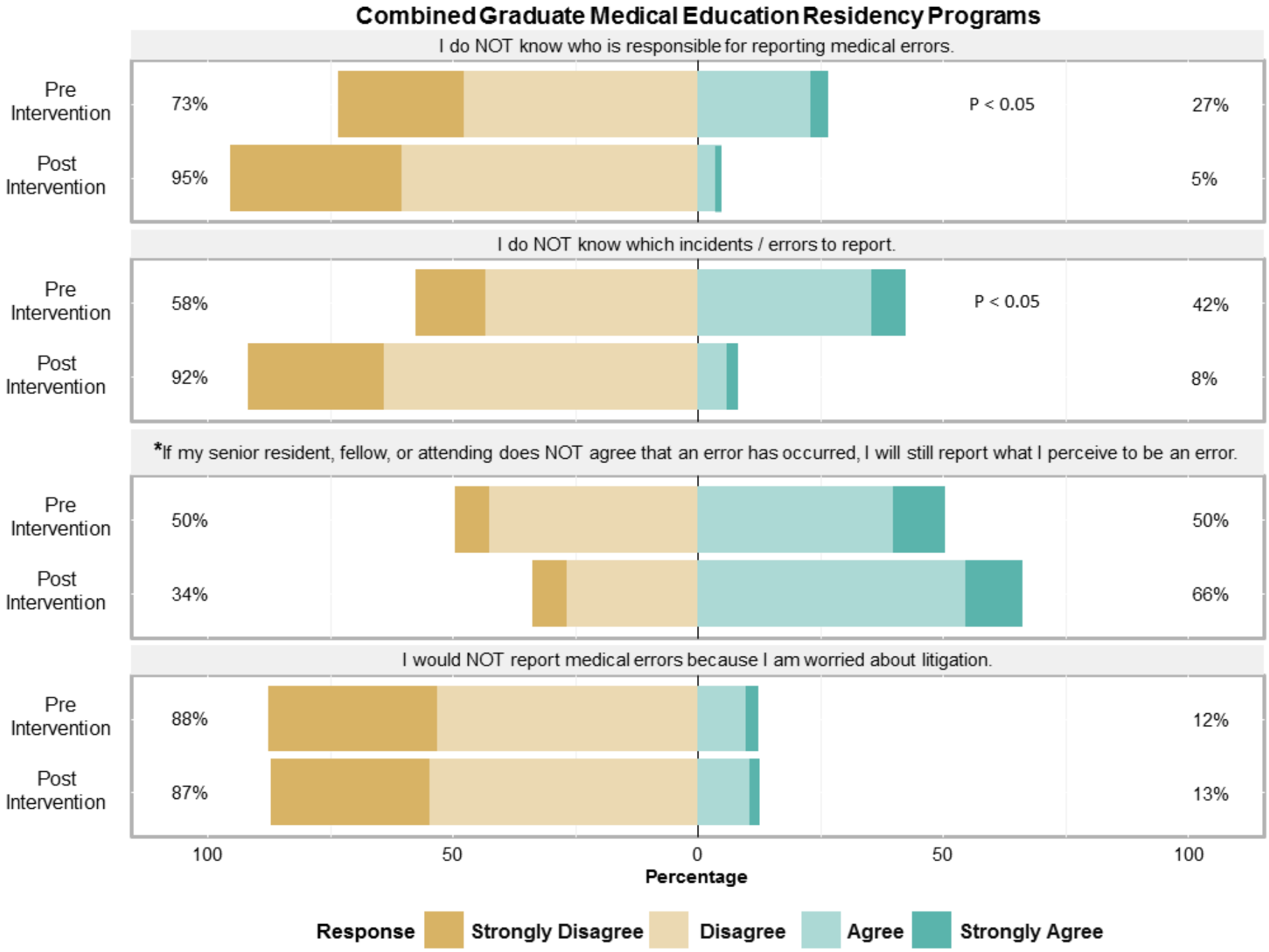
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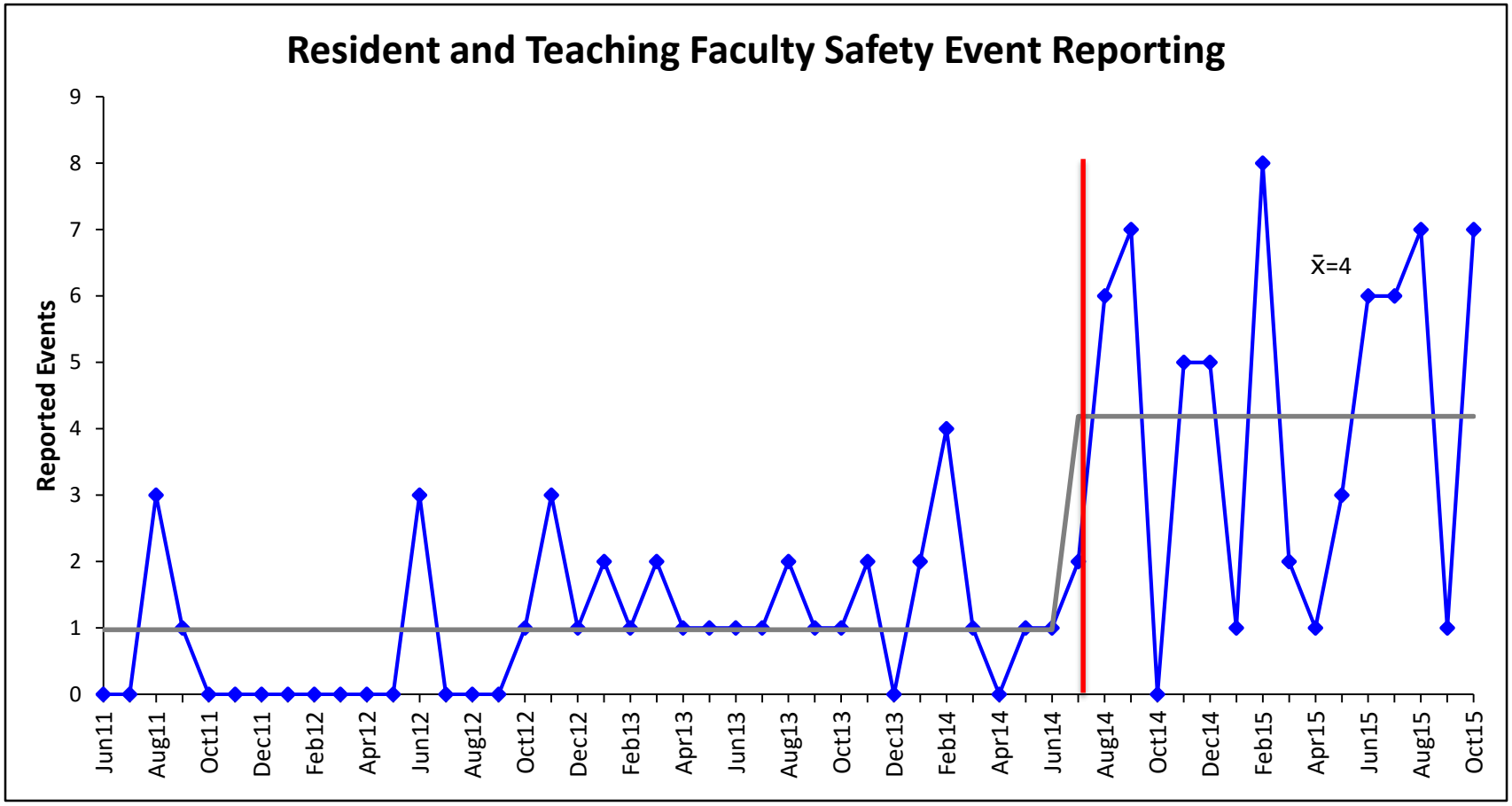
Resident and Teaching Faculty Safety Event Reporting
Reported Events
0
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4
5
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9
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Aug11
Oct11
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Feb12
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Apr14
Jun14
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Oct14
Dec14
Feb15
Apr15
Jun15
Aug15
Oct15

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# Lessons Learned

| Barriers Encountered | Lessons Learned & Opportunities for Improvement |
|---|---|
| Our current system is unable to track or access anonymous reports. | The excluded residents and teaching faculty that reported anonymously would have contributed to overall improvement in events reported. |
| Due to time constraints and administrative burden, physicians are reluctant to report events. | Continue to simplify the reporting process or assign a designated patient safety administrator to call for reporting events. |
| Our current system lacks a direct feedback process to the reporter after an event is analyzed. | Improve direct and timely feedback to the reporter indicating the change or improvement that resulted from the report. |
| Across GME, we observed differing responses to same questions that may have reflected program differences for reporting. | Provide ongoing education to residents and teaching faculty. |
| Most residents and teaching faculty did not have error reporting in medical school. | Provide ongoing education to highlight importance of event reporting to maintain sustainability. |

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# Take Aways

- Aligned residents with institution initiative
- Residents took ownership of reporting process
- Opened communication across the healthcare team
- Report feedback process is critical to residents

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Baystate Health

# Creating Psychological Safety

Doug Salvador MD MPH
Vice President, Medical Affairs
Baystate Medical Center

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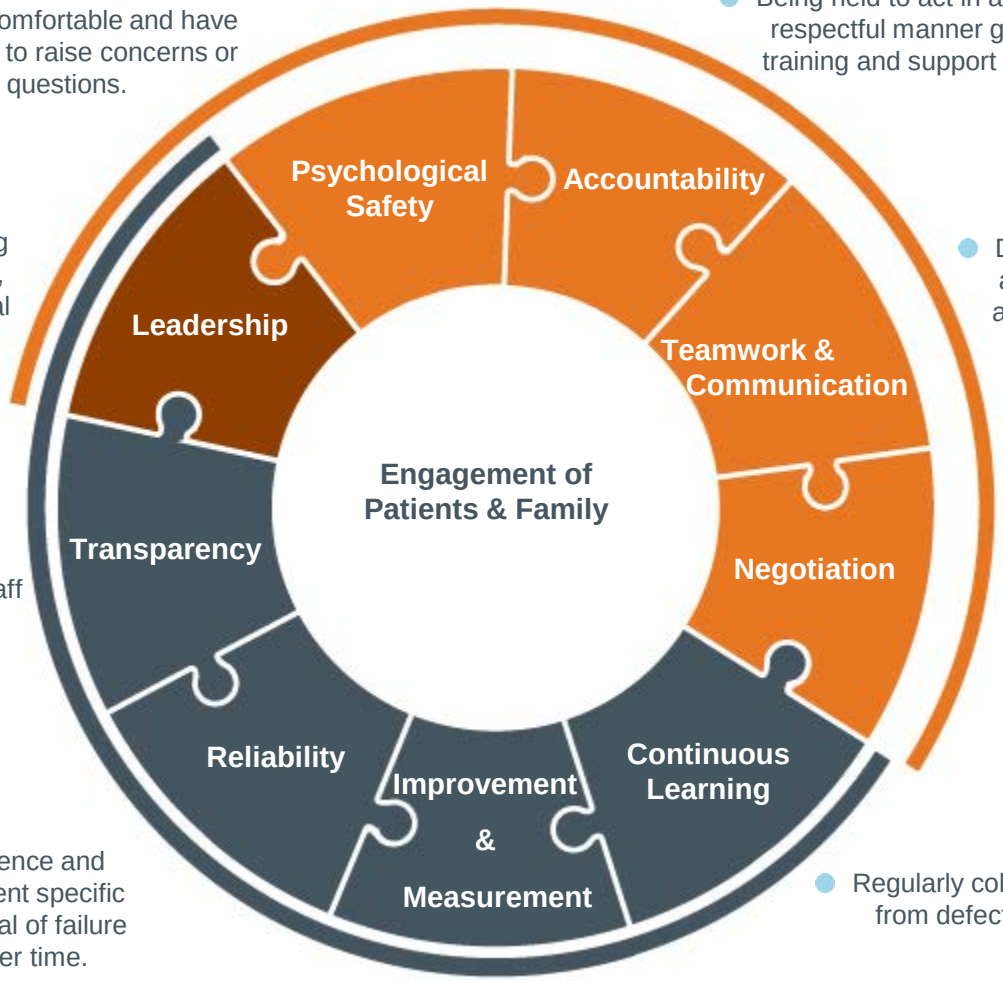
# A PATIENT STORY

# Framework for Clinical Excellence

- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.
- Being held to act in a safe and respectful manner given the training and support to do so.
- Facilitating and mentoring teamwork, improvement, respect and psychological safety.
- Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations
- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.
- Gaining genuine agreement on matters of importance to team members, patients and families.
- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.
- Regularly collecting and learning from defects and successes.
- Improving work processes and patient outcomes using standard improvement tools including measurements over time.



# BHMIS FRAMEWORK

## CULTURE

- Leadership
- Psychological Safety
- Teamwork
- Accountability

## LEARNING

- Transparency
- Measurement
- Improvement
- Reliability

# Psychological Safety

**We are our own image consultants and best image protectors**

**To protect one's image, if you don't want to look:**

| | |
|---|---|
| STUPID | **Don't ask questions** |
| INCOMPETENT | **Don't ask for feedback** |
| NEGATIVE | **Don't be doubtful or criticize** |
| DISRUPTIVE | **Don't suggest anything innovative** |

PSYCHOLOGICAL SAFETY CHANGES THIS PARADIGM



Source: Amy Edmondson

# Psychological Safety

- Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.

- A shared sense of psychological safety is a critical input to an effective learning system.
- Allows cross-disciplinary teams to overcome inhibiting effects of status differences
- Psychological safety predicts engagement in quality improvement work

Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, Vol. 44, No. 2 (Jun., 1999), pp. 350-383
Amy Edmondson

Nembhard IM Edmondson AC. *Journal of Organizational Behaviour* 2006 27:941-966

# Culture: Psychological Safety Behaviors

- Does not judge
- *Asks about breaches* in professionalism & psychological safety
- Encourages team members *to cross monitor and report difficult interactions*
- Makes *personal connection* with all
- Ensures *familiarity among team*
- *Models* responding to feedback positively

# Pediatrics, 2015

## The Impact of Rudeness on Medical Team Performance: A Randomized Trial

Arieh Riskin, MD, MHA[a,b], Amir Erez, PhD[c], Trevor A. Foulk, BBA[c], Amir Kugelman, MD[b], Ayala Gover, MD[d], Irit Shoris, RN, BA[b], Kinneret S. Riskin[a], Peter A. Bamberger, PhD[a]

abstract

**BACKGROUND AND OBJECTIVES:** Iatrogenesis often results from performance deficiencies among medical team members. Team-targeted rudeness may underlie such performance deficiencies, with individuals exposed to rude behavior being less helpful and cooperative. Our objective was to explore the impact of rudeness on the performance of medical teams.

**METHODS:** Twenty-four NICU teams participated in a training simulation involving a preterm infant whose condition acutely deteriorated due to necrotizing enterocolitis. Participants were informed that a foreign expert on team reflexivity in medicine would observe them. Teams were randomly assigned to either exposure to rudeness (in which the expert's comments included mildly rude statements completely unrelated to the teams' performance) or control

# Diagnostic Performance

**TABLE 2** Comparison of Mean Diagnostic Performance Variables ($N = 72$)

| Variable | Control Group ($n = 33$) | | Rudeness Group ($n = 39$) | | $t$ Test | $P$ (One-Tailed) |
|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | | |
| Diagnosed respiratory distress | 3.39 | 1.07 | 3.20 | 1.00 | 0.772 | .2215 |
| Diagnosed shock | 2.88 | 1.32 | 2.08 | 1.08 | 2.836** | .003 |
| Suspected infection | 3.13 | 1.01 | 3.06 | 1.13 | 0.272 | .3935 |
| Diagnosed NEC | 3.08 | 1.23 | 2.62 | 0.95 | 1.76* | .0415 |
| Good stage 1 diagnostic skills | 3.22 | 0.99 | 2.91 | 0.75 | 1.498 | .0695 |
| Diagnosed deterioration | 4.05 | 0.75 | 3.54 | 0.89 | 2.562** | .0065 |
| Suspected perforation of bowel | 2.60 | 1.47 | 1.94 | 0.96 | 2.297* | .0125 |
| Diagnosed cardiac tamponade | 3.18 | 1.30 | 2.15 | 1.40 | 3.214** | .001 |
| Good stage 2 diagnostic skills | 3.13 | 1.21 | 2.35 | 1.07 | 2.881** | .0025 |
| Overall diagnostic | 3.18 | 0.92 | 2.65 | 0.69 | 2.796** | .00035 |

*$P < .05$, **$P < .01$.

# Procedural Performance

**TABLE 3** Comparison of Mean Procedural Performance Variables ($N = 72$)

| Variable | Control Group (n = 33) | | Rudeness Group (n = 39) | | *t* Test | *P* (One-Tailed) |
|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | | |
| Performed resuscitation well | 3.05 | 0.84 | 2.49 | 0.73 | 3.00** | .002 |
| Ventilated well | 3.43 | 0.94 | 3.01 | 0.81 | 2.029** | .0023 |
| Verified place of tube well | 3.56 | 0.88 | 2.85 | 0.82 | 3.492** | .0005 |
| Asked for right radiographs | 3.29 | 1.23 | 2.96 | 1.50 | 0.994 | .162 |
| Asked for right laboratory tests | 3.78 | 0.89 | 3.24 | 0.94 | 2.382* | .01 |
| Gave right resuscitation medications | 3.55 | 0.81 | 3.17 | 1.08 | 1.639 | .053 |
| Stopped percutaneous central line on time | 2.95 | 1.35 | 2.36 | 1.44 | 1.764* | .041 |
| Prepared and performed pericardiocentesis | 2.71 | 1.55 | 2.24 | 1.39 | 1.301 | .099 |
| Good general technical skills | 3.17 | 0.88 | 2.61 | 0.73 | 2.869** | .0025 |
| Overall procedural | 3.26 | 0.72 | 2.77 | 0.67 | 2.974** | .0002 |

*$P < .05$, **$P < .01$.

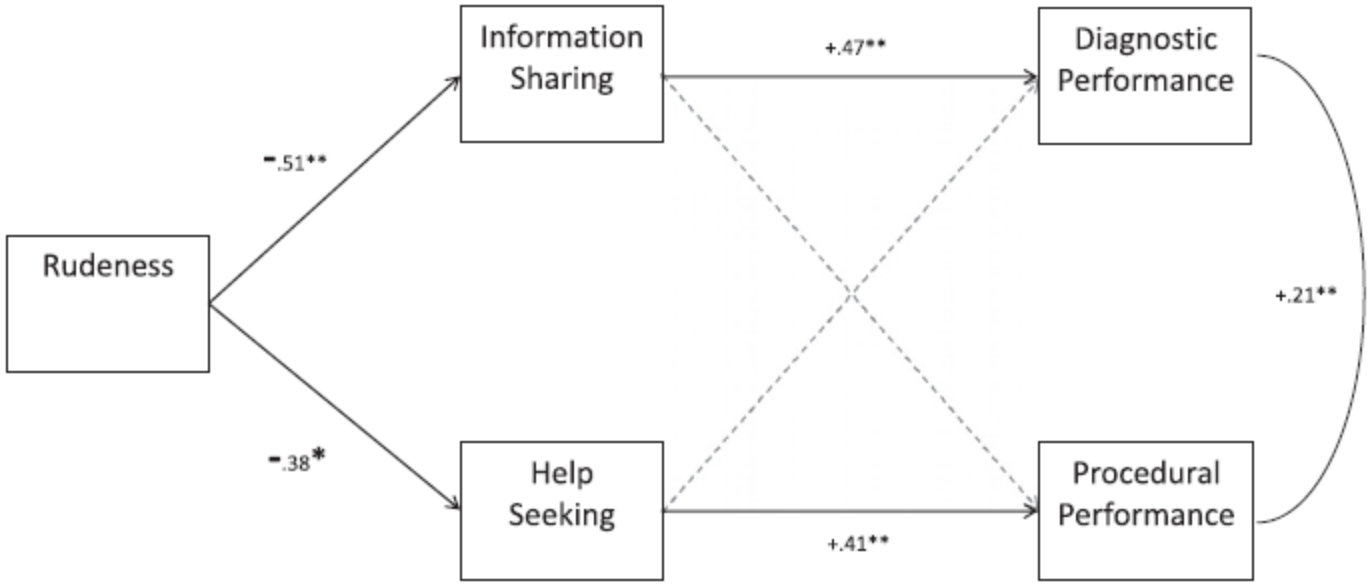



**FIGURE 1**
Path model of the effect of rudeness on performance, mediated by information-sharing and help-seeking. Numbers denote standardized coefficients for the mediation path shown by the arrow. The relationship between information-sharing and help-seeking was 0.37.* The relationships between information-sharing and procedural performance and between help-seeking and diagnostic performance were not significant. *$P < .05$, **$P < .01$.

# Culture of Safety Survey 2015

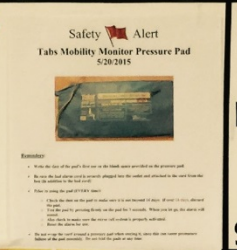
- Teamwork
  - 39% say it is difficult to speak up with a problem about patient care
  - 42% say disagreements are resolved appropriately
  - 66% say dealing with difficult colleagues is consistently a challenging part of my job

# DALY 6-2 Huddle Board

| HD | QUALITY | SERVICE | COST |
|---|---|---|---|
| | # FALLS 6\|1, 6\|5, 6\|14<br>TABS: 65B, 68B, 81A, 84A | % OF PATIENTS ON IPOC ___ | IHPPD ___ |
| | 5 FOLEY CATHETERS<br>LAST CAUTI: 519 | DISCHARGES | PATIENTS WITH LOS >9 DAYS 8 |

## POLICY UPDATES

Patients with Parainfluenza should have ***Contact Isolation*** initiated. Many of the patients are found to have only Droplet or Contact/Droplet. Please be sure to initiate the correct isolation for these patients. Thank you!



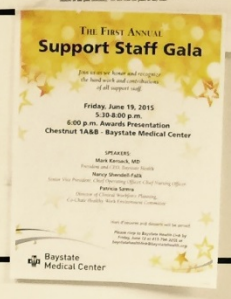

## EQUIPMENT:


## ENVIRONMENT:

## SUPPLIES:

## RECOGNITION

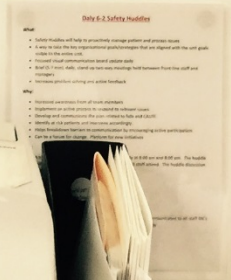
2 weeks with no missing zipits! Great!

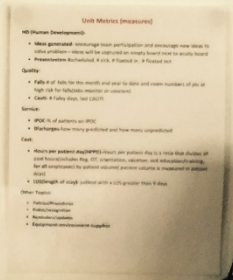



## REMINDERS

Please p/u zipit before getting report/return clean zipit after giving report! Thank you!

Ambassador 90782
Resp 90526



# Breaches in Psychological Safety

- Facilitated discussion between the individuals in conflict

- “Cultural defects” are as important as clinical or process defects and must be resolved

# Impact

- Thank you Shawna! I appreciate your supportive and kind words the other morning. It is not easy for me to put myself out there in situations like that. It is nice to know that a meeting was implemented. Even the littlest gesture may go a long way. He checked in with me for the following two nights that I had his patient and he was very polite. The road has to start somewhere! Thank you again.


# Team Competency in Action

## Attestation Procedural Pause

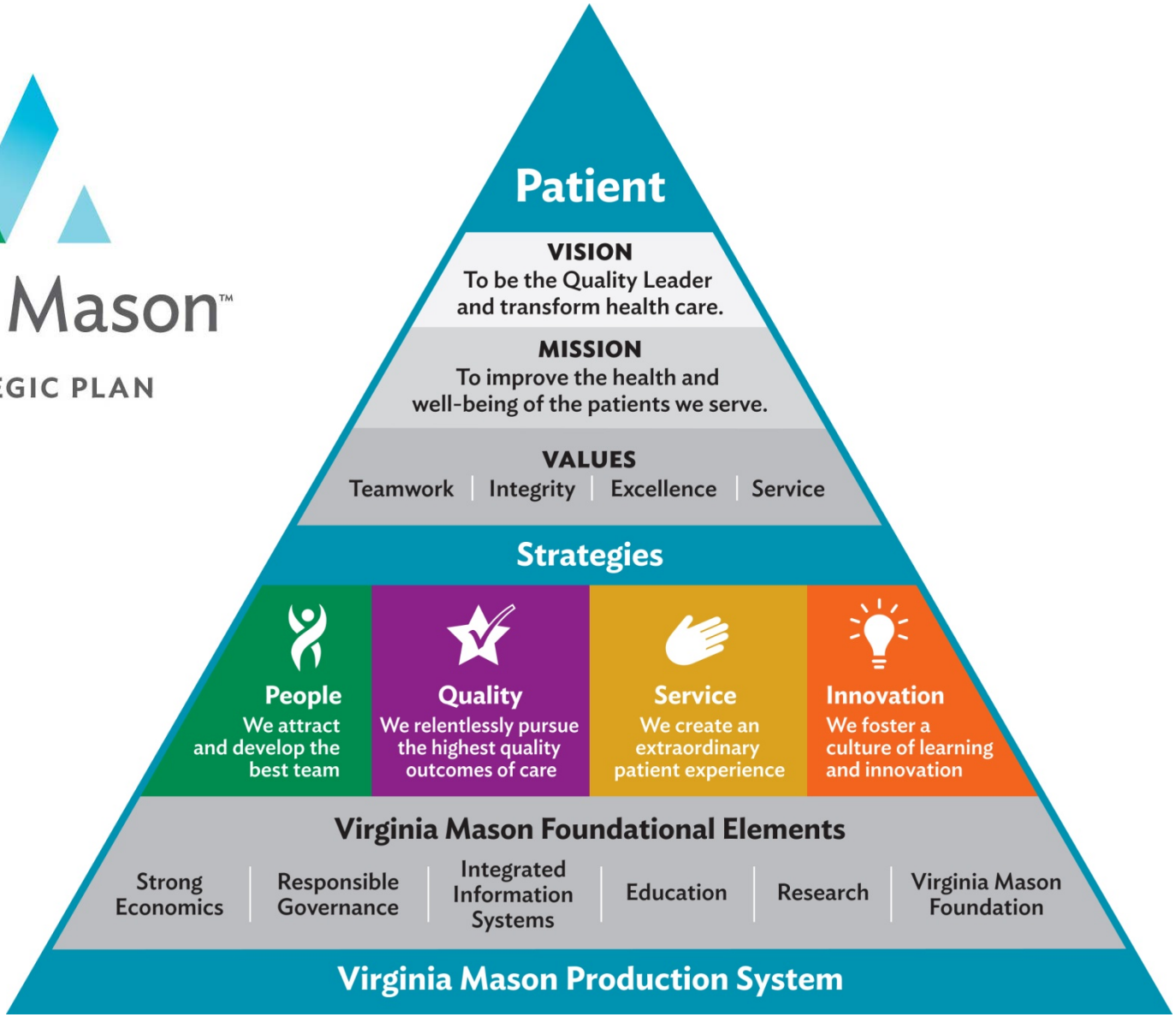
Brian D. Owens, MD

AIAMC Annual Meeting

April 1, 2016

Virginia Mason™

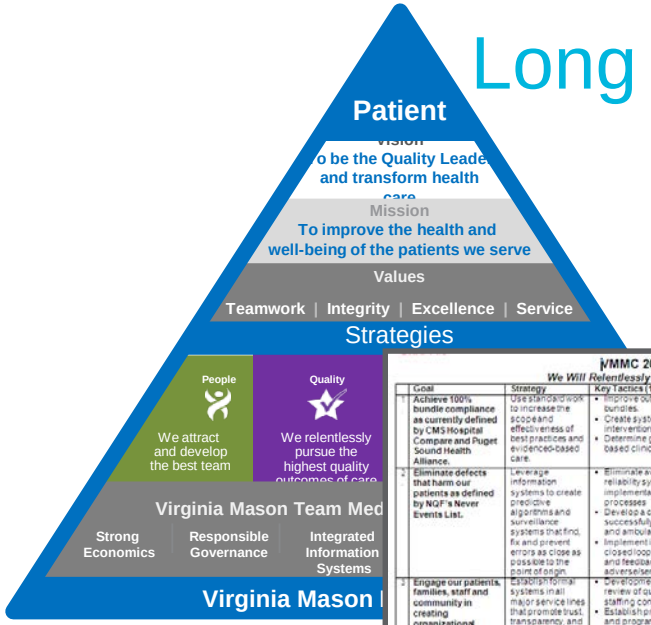
OUR STRATEGIC PLAN



# Alliance of Independent Academic Medical Center National Initiative

- GME as a Driver of Patient Safety
- Tools and Resources to Align the Organization
- National Initiative I: Handoffs
- National Initiative II: Patient Safety Curriculum—Perioperative Attestation
- National Initiative III: Patient Safety and Quality Improvement Faculty Development
- National Initiative IV: Health Care Quality, Disparities, Literacy
- National Initiative V: Improving Community Health and Health Equity Through Medical Education—Identifying and Helping Those who Struggle with Alcohol Misuse

# Align the Vision with Resource




## Long Term Vision

## 5 Year Plans

VMMC 2008-2012 Strategic Quality Plan

*We Will Relentlessly Pursue the Highest Quality Outcomes of Care*

| | Goal | Strategy | Key Tactics (1-2 years) | Metrics |
|---|---|---|---|---|
| 1 | Achieve 100% bundle compliance as currently defined by CMS Hospital Compare and Puget Sound Health Alliance. | Use standard work to increase the scope and effectiveness of best practices and evidenced-based care. | • Improve outcomes of care through increased compliance with patient care bundles.<br>• Create systematic delivery of on-time, effective and appropriate preventive health interventions for the patients.<br>• Determine governance structure and support requirements to optimize evidence-based clinical decision-making. | 1. % of Publicly Reported Inpatient Metrics in the Top Tenth Percentile<br>2. % of Publicly Reported Ambulatory Metrics at or above regional average |
| 2 | Eliminate defects that harm our patients as defined by NQF's Never Events List. | Leverage information systems to create predictive algorithms and surveillance systems that find, fix and prevent errors as close as possible to the point of origin. | • Eliminate avoidable injuries across the continuum of care by creating high reliability systems that detect risk through use of tools, ongoing surveillance and implementation of prevention and treatment measures and coordination of care processes<br>• Develop a comprehensive Infection Prevention & Control Program that will successfully eliminate healthcare associated infections (HAIs) in the acute care and ambulatory settings.<br>• Implement improvements in the Patient Safety Alert (PSA) system that provides a closed loop communication process for all yellow PSAs, timely acknowledgement and feedback to staff | 3. Unadjusted Raw Mortality<br>4. Nosocomial Injury Rate<br>(includes Retained Objects, Air emboli, Transfusion Events, Urinary Tract Infections, Blood Stream Infections and Pressure Ulcers) |
| 3 | Engage our patients, families, staff and community in creating organizational processes that strengthen our culture of healthcare quality and safety. | Establish formal systems in all major service lines that promote trust, transparency, and a commitment to quality and safety. | • Development and p<br>review of quality ind<br>staffing concerns p<br>• Establish process fo<br>and program develo<br>• Design and implem<br>educational curricul | |
| 4 | Create efficient, integrated systems of care that reduce the costs associated with poor quality. | Develop novel systems for handoffs and information sharing to optimize the flow of healthcare at every point of service. | • Optimize effectiven<br>perfect transition fro<br>communication and<br>• Create an intake ce<br>on the placement of<br>care.<br>• Enhance informatio<br>information flow dur | |
| 5 | Accelerate Virginia Mason's leadership in quality and safety with valid, actionable, and relevant metrics. | Establish the infrastructure needed to measure and monitor our leadership in quality and safety. | • Create and implem<br>compliance monitor<br>care and improve bu<br>• Design and implem<br>safety information to<br>• Evaluate our positio<br>opportunities using | |

## Annual Goals

### Quality and Safety

1. Ambulatory Prevention Bundles
2. Optimize Care Transitions
3. Zero Nosocomial Injuries
   - Fall Prevention
   - Health-care Ac
4. Patient Safety Cu
5. Innovative Clinica

## KPO Priorities

### KPO Priorities

| Hospital | Clinic | Corporate |
|---|---|---|
| Reduce lead time | Reduce lead time | Reduce lead time |
| Improve access and level the patient flow | Improve access and day of visit work flow | Zero defects in HR/Payroll information flow |
| Eliminate falls with injury , medication errors, & unplanned readmissions | Eliminate defects in the administration of Health Maintenance Module | Eliminate defects in the Distribution of Supplies & in OR instrument sets |
| Implement Standard Work for Leaders | Implement Standard Work for Leaders | Implement Standard Work for Leaders |
| Achieve margin targets | Achieve margin targets | Achieve margin targets |

# 2010 Organizational Goals

## Quality and Safety

1. Ambulatory Prevention Bundles
2. Optimize Care Transitions
3. Zero Nosocomial Injuries
   - Fall Prevention
   - Antithrombotics
   - Health-care Acquired Infections
4. **Patient Safety Curriculum**

## Patient Satisfaction

1. Create and Sustain a Service Culture

## Staff Satisfaction

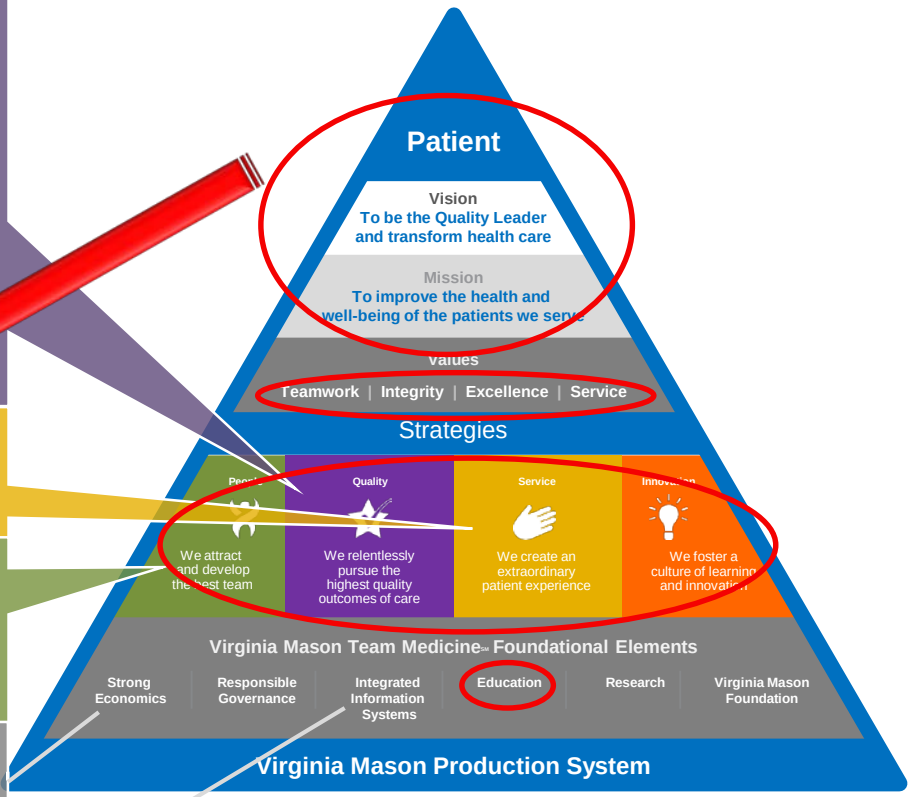
1. Staff Engagement
2. Communication
3. Leadership Development

## Strong Economics

1. Margin: Revenue Growth

## Integrated Information Systems

1. Closed Loop Medication / Bar Coding



# Aim

**What**...Develop/pilot patient safety curriculum

**Who**...Perioperative services (subset)
Hospital 7, 8, 14 (Telemetry and ACE)
Team: MDs, RNs, residents, pharmacy

**By when**...End of 2010

# WHY:

Teams that communicate effectively reduce the potential for error.

**Great teamwork =**

**– High staff engagement / satisfaction**

**– +**

**– High patient satisfaction**

# This really happened...

# NI 2: Attestation Time Out

- Current State, 2009
  - Pause is Attending Surgeon communication
  - Rolling stop
  - Team not engaged
  - Would people actually stop the line?

# NI 2: Attestation Time Out

- Process
  - Engage residents and faculty from general surgery and anesthesiology as well as OR nursing and other staff
  - Create process whereby each team member gives first and last name, responsibility and attests to what they know about the procedure.

# NI 2: Attestation Time Out

- Institutional Involvement
  - Perioperative Services makes new format a requirement
  - Educational video created
    - Demonstrate to current team members that time required for new format is less than 2 minutes
    - Orient new team members
  - Spread to all procedural areas

# NI 2: Attestation Time Out

## Outcomes

- Dr. Jon Narimasu, anesthesiology resident
  - Poster presentation, ASA, 2010
  - Topic and poster chosen for release to lay journals
- Dr. Alison Porter, general surgery resident
  - Lead article in Joint Commission Journal of Quality and Safety, Jan, 2014
- Joint Commission
  - Best Procedural Pause ever observed. “You should patent and sell it!”

# Virginia Mason™

Each Person.
Every Moment.
**Better Never Stops.**