



# KEEPING PATIENTS SAFE--- ONE DAY AT A TIME

**Texas Department of  
Health Services  
August 28, 2019**



# OBJECTIVES



1. Determine actions to improve patient safety culture in your work environment
2. Apply system design improvements to your daily processes to achieve high reliability

# CENTER FOR PATIENT SAFETY



Independent not-for-profit  
Patient Safety Organization



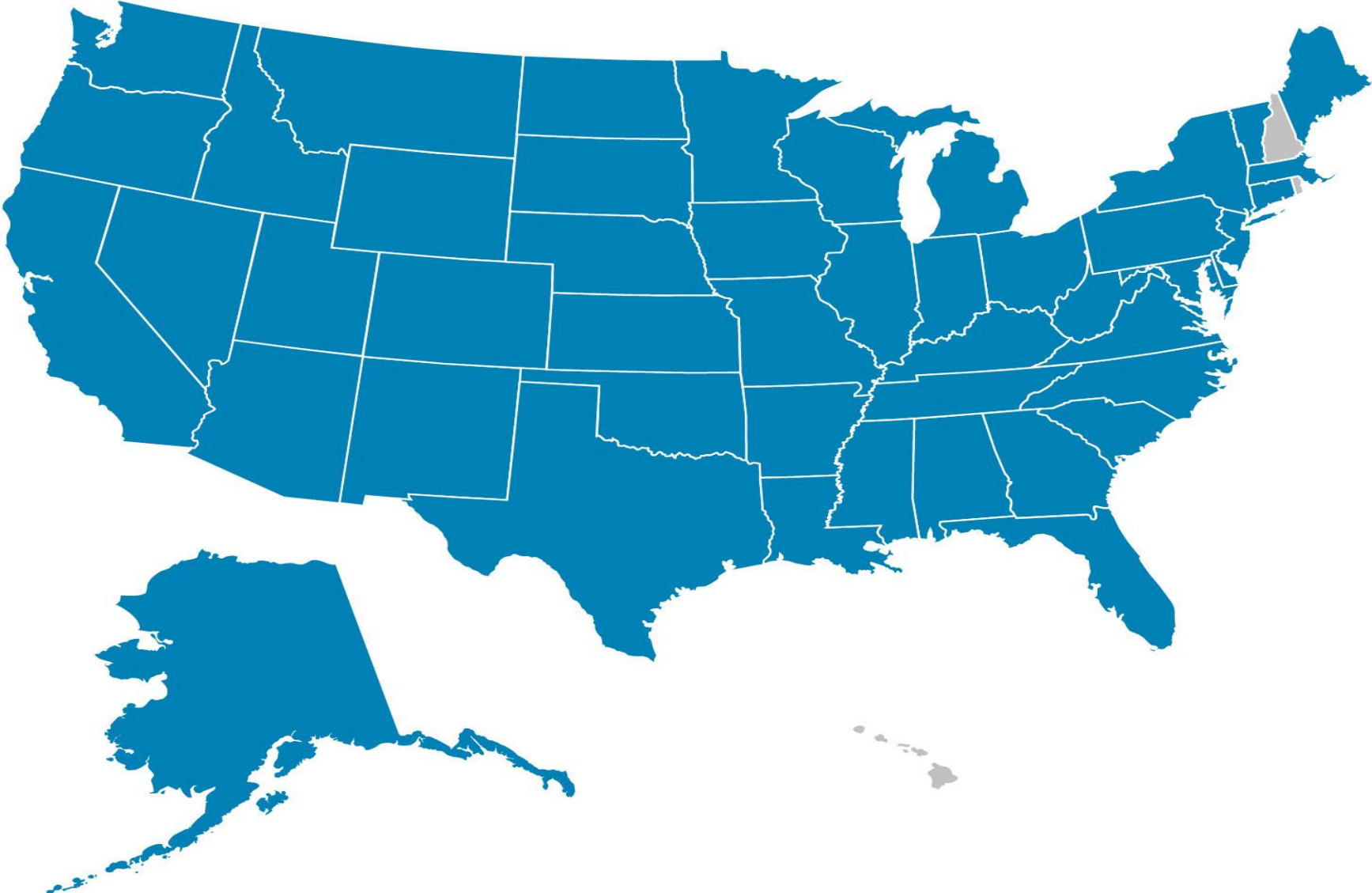
Established in 2005



Patient safety resources and  
services for hospitals, health  
systems, ambulance services,  
physician offices, pharmacies,  
nursing homes, home health &  
hospices



# CURRENT CPS PSO SERVICES



# OUR MISSION

Reducing patient harm



## OUR VALUES

- Integrity
- Culture of Patient Safety
- Excellence
- Advocacy

# CREATING A PATIENT SAFETY CULTURE



# PATIENT SAFETY EVALUATION

TOPIC	REACTIVE (0)	SYSTEMATIC (1)	PROACTIVE (2)	GENERATIVE (3)	HIGHLY RELIABLE (4)	SCORE
DESCRIPTOR						
LEADERSHIP	<p>Patient Safety systems and processes to promote a culture of improving patient safety not utilized. (i.e. strategic plan, patient safety assessments and measures, event reporting system just culture, patient safety education and training, peer review, Second victim program, simulation)</p>	<p>Leaders set the vision to reduce preventable patient harm. Patient safety is a value and integrated in strategic and daily operations. A few systems in place to promote healthy patient safety culture.</p>	<p>Dedicated resources committed to patient safety efforts (i.e. time, financial, designated champion) Patient safety culture assessed on a regular basis. Leaders consistently include patient safety and quality topics and measures on all agendas.</p>	<p>Results of patient safety culture assessment used to identify and implement patient safety improvements or initiatives utilizing standard processes such as standardized patient handoffs. Participates in a Patient Safety Organization (PSO). Implements a peer-to-peer review process. Second Victim program initiated. Staff rewarded for patient safety improvement ideas and initiatives.</p>	<p>Managing patient safety in all operations. Non-punitive error reporting, near miss tracking, High reliability characteristics embedded in the organization: preoccupation with failure, reluctance to simplify operations while exuding a commitment to resilience.</p>	

# PATIENT SAFETY EVALUATION SCORING

- **20 – 19** = Your organization has achieved **High Reliability** patient safety rating. The organization has done a great job achieving this level. Consider reaching out to the Center for Patient Safety to share your success stories. Keep up the good work!
- **18 – 15** = Your organization has achieved **Generative** patient safety rating. The organization has taken the steps to improve patient safety and is almost at the high reliability point. A little more effort and your organization will achieve the next level of patient safety evolution!
- **14 – 10** = Your organization has achieved a **Proactive** patient safety rating. The organization has taken specific steps to move to an important step towards high reliability. The efforts made are important and the organization is encouraged to keep working towards the next level of patient safety growth!
- **9 - 5** = Your organization has achieved **Systematic** patient safety rating. The organization has moved from the pivotal step of reactive to being more aware to make positive patient safety changes.
- **> 4** = Your organization has achieved a **Reactive** patient safety rating. The organization focuses only on regulatory requirements and views events as inevitable and the cost of doing business. The organization should seek mentorship from agencies that have moved further along in the patient safety journey.
-



# GOAL: REDUCE PATIENT HARM

Apply the safety science methods to achieve a trustworthy health care delivery system

Minimize the number and impact of adverse events and maximize recovery from events

Methods for implementing change, including cultural

Understand the **sharp** and **blunt** end of the stick as it pertains to clinical errors

# CULTURE SHAPES....

- Attitudes and perceptions
- How we do things (quality)
- How we communicate
- How we work together



*“...the sum of what an organization is and does in the pursuit of safety...[and] the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety.”*

**NPSF, Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err is Human.**

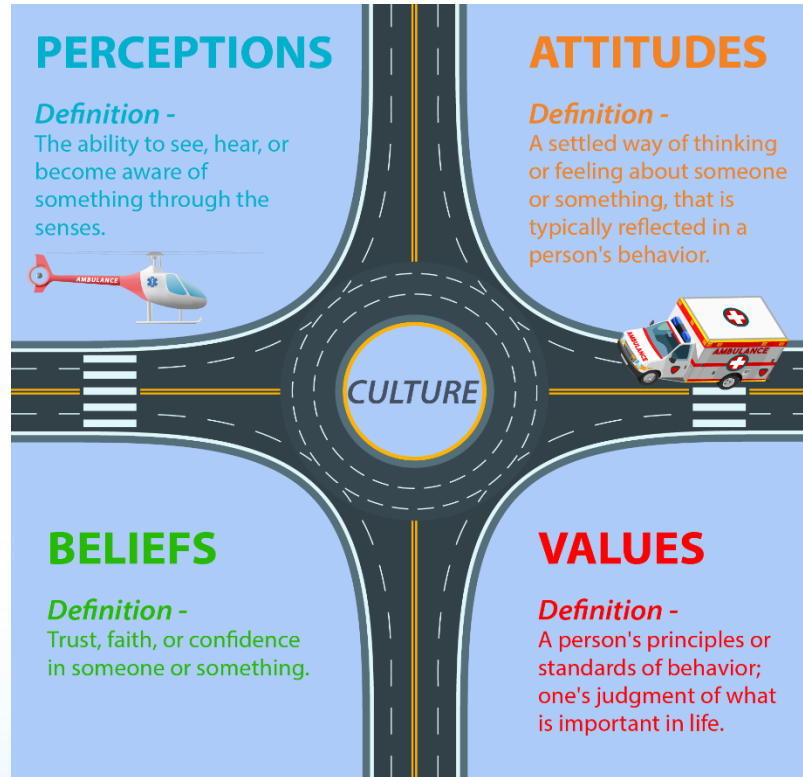
# CULTURE OF SAFETY

- Evolved from other high risk industries
- The “personality” of a workplace
- How things get done around the organization

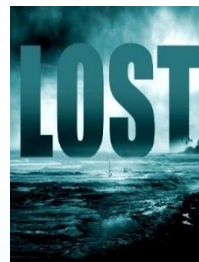


# EVERY TURN IMPACTS SAFETY

*How would you describe the culture at your organization?*



**This is what  
some people  
have told us  
their culture  
is like....**



# BAD LUCK....

## Culture of Low Expectations

- That's the way we have always done it here
- Just get it done...we are in a hurry
- Forget the book stuff, let me show you how things really get done on the street
- I know it's wrong, but the system is broken, I can't do anything about it
- It's the cost of doing business



The *culture* of an organization is the foundation for patient safety

- Culture is local
- Each clinician sees it differently
- Frontline staff versus leadership



**I ♥  
SECRET  
SAUCE**

- How would you describe the patient safety culture at your organization?
- What are your biggest barriers to patient safety culture?
- What actions can be taken to improve it?







# LEADING CULTURE CHANGE ON A DAILY BASIS

# THE BUCK STOPS HERE:

## Traits at the Top of Safe Organizations

1

Set the tone - lead by example

2

Focus on results

- Develop goals and use data
- Share and celebrate
- Everyone contributes

3

Provide infrastructure and accountability

- Resources
- Prioritizing/incentivizing
- Avoid punishing mistakes

# SET THE TONE

Helps organization  
interpret the  
vision

Articulates the  
vision

Sets the vision

# 1. HOW TO SET THE TONE

## Determine and Communicate

- Determine and communicate vision of patient safety for the organization

## Assess

- Assess priority of safety in strategic plan

## Revise Agendas

- Place safety issues prominently on all meeting agendas, including the Board

## Prioritize

- Prioritize patient safety initiatives and incentivize involvement

## Personal Growth

- Continually gain personal knowledge about patient safety and quality improvement; engage in walk-arounds and safety briefings

## 2. HOW TO FOCUS ON RESULTS

### Develop and Support

- Develop and support measurements and goals for patient safety initiatives and improvement teams

### Share

- Share results with Board and staff

### Set Expectations

- Define expectations and encourage everyone to participate in achieving goals

### Celebrate

- Celebrate successes

# 3. HOW TO PROVIDE INFRASTRUCTURE AND ACCOUNTABILITY

<b>Provide</b>	Provide finances and staff to support quality/patient safety initiatives
<b>Consider</b>	Consider establishment of a Patient Safety Committee
<b>Assign</b>	Assign senior leader as resource for all safety performance teams/projects and review outcomes regularly
<b>Identify Champion</b>	Identify individual to be “patient safety champion” for the organization
<b>Provide Support</b>	Provide support programs focusing on caring for providers, ie Second Victim Program
<b>Avoid</b>	Avoid punishing mistakes

# BARRIERS OF CREATING A SAFETY CULTURE

Lack of  
Leadership  
involvement

Minimal  
foundational  
understanding

Lack of data

Organizational  
silos

Time

Focusing on  
the wrong  
things

# REMOVING THE BARRIERS

Leadership  
involvement-  
“Walk the talk”

Learn  
and teach

Look for the  
data

Break down  
the silos

Make the time

Don't focus on  
the wrong  
things





# EINSTEIN -- THE NEED FOR CHANGE

*“Insanity: doing the same thing over and over again and expecting different results.”*

***“We cannot solve our problems with the same thinking we used when we created them.”***

# OBSTACLES TO CHANGE

Why am I not getting the change I want?

CASE FOR CHANGE	VISION	SKILLS	INCENTIVES	RESOURCES	ACTION PLAN	OUTCOME
	Vision	Skills	Incentives	Resources	Action Plan	Status Quo
Case for Change		Skills	Incentives	Resources	Action Plan	Confusion
Case for Change	Vision		Incentives	Resources	Action Plan	Anxiety
Case for Change	Vision	Skills		Resources	Action Plan	Gradual Change
Case for Change	Vision	Skills	Incentives		Action Plan	Frustration
Case for Change	Vision	Skills	Incentives	Resources		False Starts

Source: Dr. Mary Lippert, Managing Complex Organizational Change

# 12 STEPS TO EMBED PATIENT SAFETY

Set	Set patient safety goals and include in strategic plan
Assign	Assign “patient safety champion” and revise job description
Ensure	Ensure all employees receive patient safety training
Implement and support	Implement and support front-line accountability
Support and encourage	Support and encourage error and near miss reporting
Identify and discuss	Identify and discuss at least one patient safety concern each month

# 12 STEPS TO EMBED PATIENT SAFETY

Foster

Foster organizational learning and share lessons learned with expectations for front-line adoption

Incorporate

Incorporate safety rounding as an organizational standard practice

Assign

Assign a senior leader to each improvement project/team

Acknowledge

Acknowledge project/team accomplishments

Provide

Provide opportunities for front-line staff to share success stories with management and each other

Celebrate

Celebrate successes

# SAFETY IS NOT OUR TOP PRIORITY

Our top priority is getting oil out of the ground.

However, when safety and productivity conflict, then safety takes priority.



- From a leadership perspective, what is the biggest barrier:
  - Lack of focus?
  - Lack of results?
  - Lack of infrastructure?
- What will you do to lead patient safety in your organization?



# EVENT REPORTING AND TRANSPARENCY







# ERROR TYPES

## Skill based

- Slips and lapses - forgot
- Actions not carried out as intended or planned
- Makes most benign tasks dangerous

## Rule based

- Did something believing it to be correct when it was wrong
- Faulty plan or intention

## Knowledge based

- Don't know what you don't know
- Incomplete understanding

# WHY ERRORS HAPPEN

- Variable input (different clinicians)
- Inconsistency/variation  
equipment
- Complexity in processes
- Too many/complicated steps
- Supplies/equipment
- No checklist for critical  
interventions
- Tight time constraints(hurried)
- Lack of standardized processes
- Hierarchical culture
- Fatigue
- Inattention/distractions
- Unfamiliar situations/new  
problem
- Using past solutions
- **Authority gradient**
- Communications errors
- Lack of teamwork
- Biases

**Process Factors**

**People Factors**



**What to Report?**

**When to Report?**

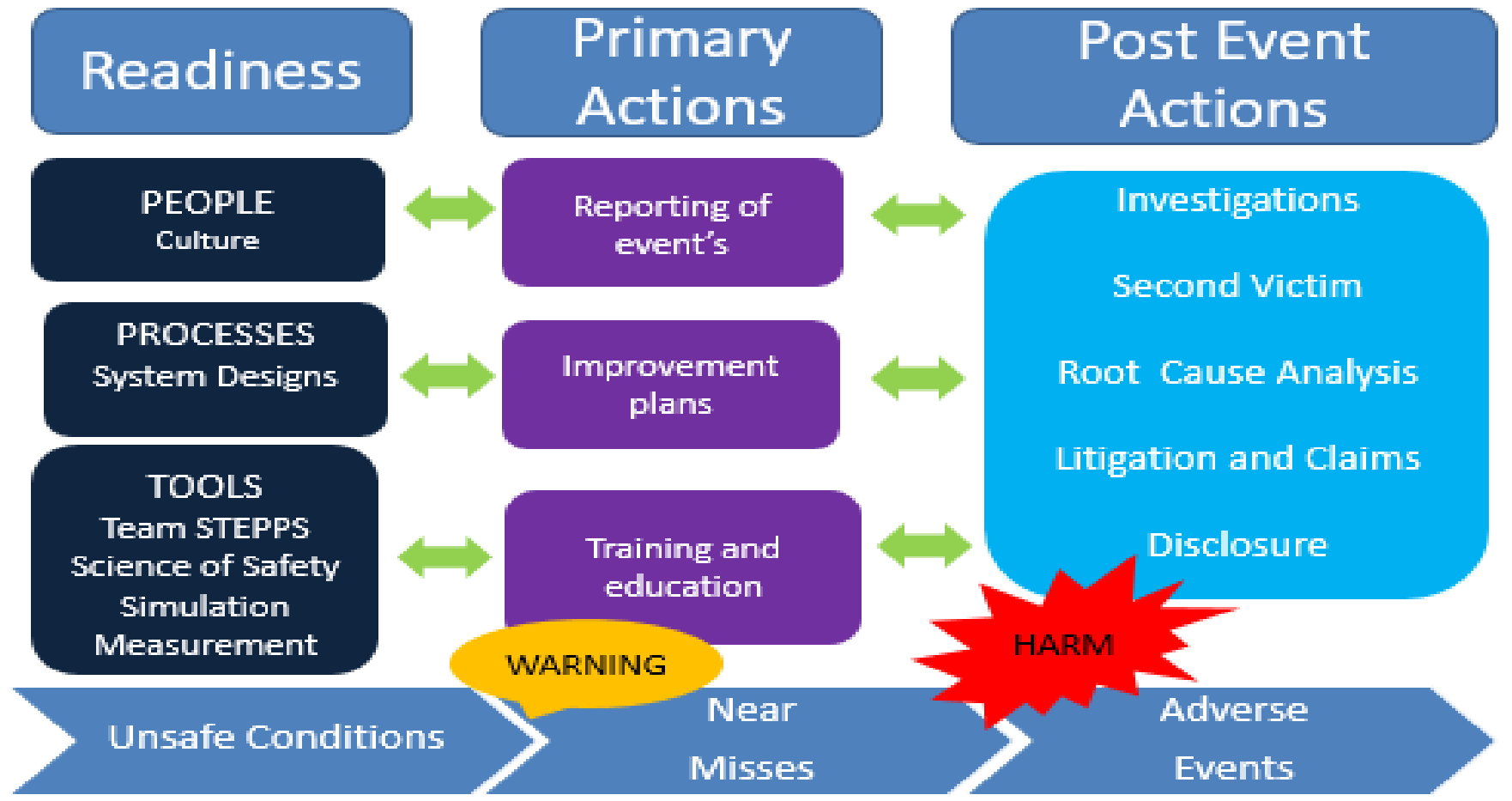
**How to Report?**

**Incident**

**Near Miss**

**Sentinel Event**

# EVENT PROCESS FLOW



# SUCCESSFUL EVENT REPORTING

- Culture - just, reporting, flexible, learning
- Support, encouragement and trust of leadership
- Treats less experienced staff as professionals
- Accept human fallibility
- Patient safety training
- Ground rules for acceptable and unacceptable behaviour
- Actions taken -- with consistent feedback
- Anonymity
- Confidential



# IMPORTANCE OF EVENTS AND INVESTIGATIONS

- Events are the window into an organization's safety and reliability.
- To manage risk, we have to see those things
- Reports and investigations give us better information about our risk





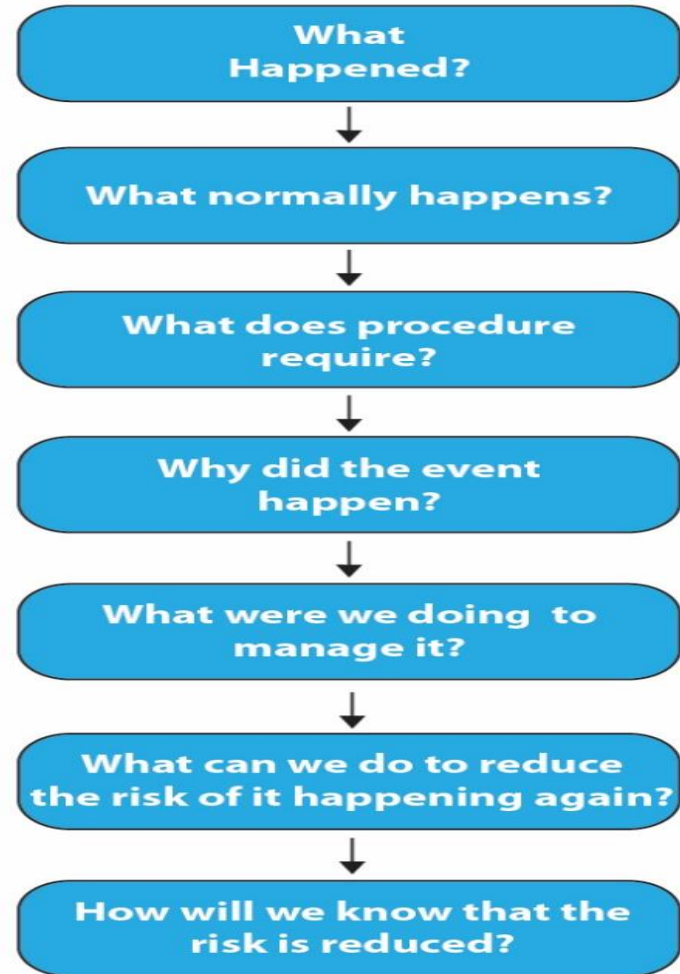
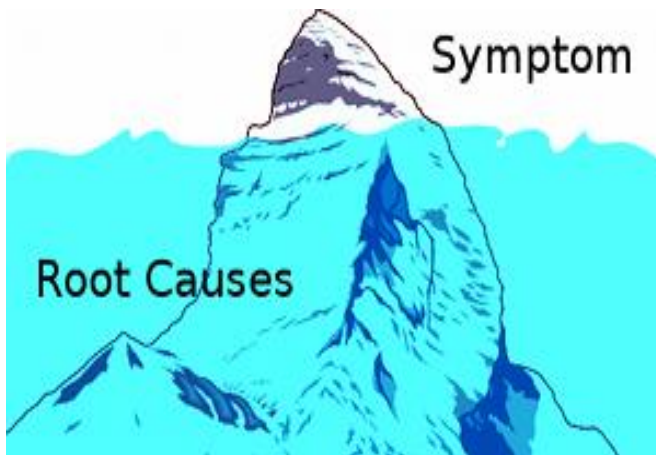
# ROOT CAUSE ANALYSIS: The Good, the Bad and the Ugly

**Goal:** Identify changes that will improve care with respect to an undesired outcome

## **5 Steps:**

1. Gather facts and learn what happened
2. Generate deep discussion of possible causes
3. Identify factors in environment at time of event
4. Develop list of actions
5. Review

# TEMPLATE FOR ROOT CAUSE ANALYSIS



# MAKING SOLUTIONS REAL: Action Plans

*“Plans are only good intentions unless they immediately degenerate into hard work.”*

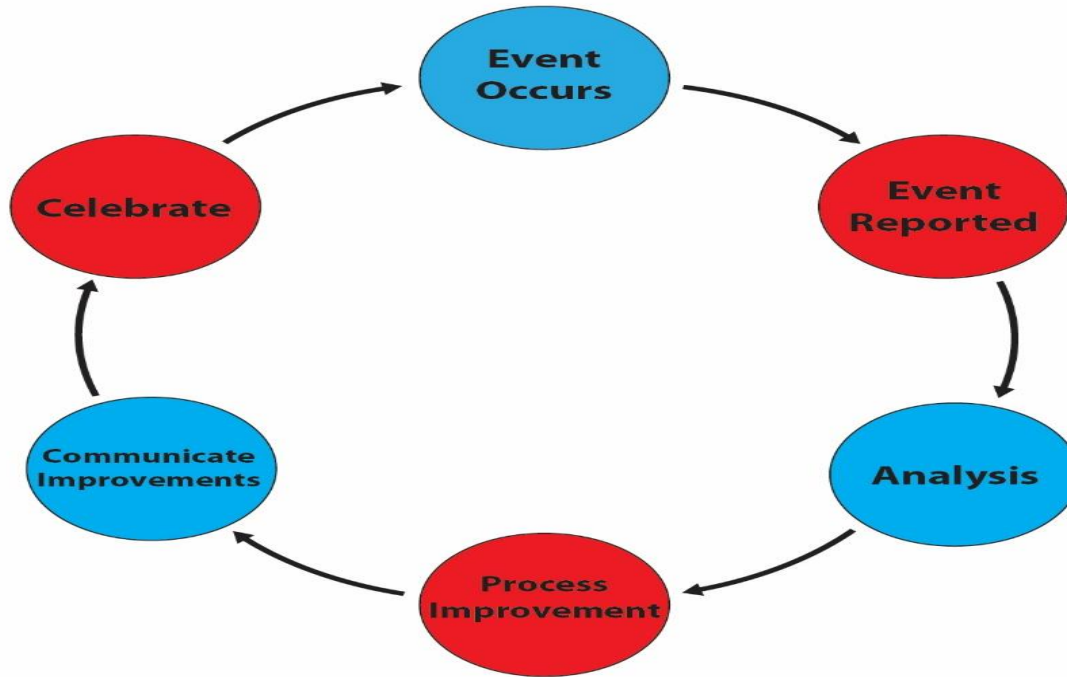
Peter Drucker



# PROJECT ACTION PLAN

PROJECT ACTION PLAN						
GOAL 1						
Write your goal statement here.						
ACTION STEP DESCRIPTIONS	PARTY / DEPT RESPONSIBLE	DATE TO BEGIN	DATE DUE	RESOURCES REQUIRED (staff, tech, etc. )	DESIRED OUTCOME	NOTES
GOAL 2						
Write your goal statement here.						
ACTION STEP DESCRIPTIONS	PARTY / DEPT RESPONSIBLE	DATE TO BEGIN	DATE DUE	RESOURCES REQUIRED (staff, tech, etc. )	DESIRED OUTCOME	NOTES
GOAL 3						
Write your goal statement here.						
ACTION STEP DESCRIPTIONS	PARTY / DEPT RESPONSIBLE	DATE TO BEGIN	DATE DUE	RESOURCES REQUIRED (staff, tech, etc. )	DESIRED OUTCOME	NOTES
GOAL 4						
Write your goal statement here.						
ACTION STEP DESCRIPTIONS	PARTY / DEPT RESPONSIBLE	DATE TO BEGIN	DATE DUE	RESOURCES REQUIRED (staff, tech, etc. )	DESIRED OUTCOME	NOTES
GOAL 5						
Write your goal statement here.						
ACTION STEP DESCRIPTIONS	PARTY / DEPT RESPONSIBLE	DATE TO BEGIN	DATE DUE	RESOURCES REQUIRED (staff, tech, etc. )	DESIRED OUTCOME	NOTES

# CHANGING THE CULTURE



# SECOND VICTIM

- Connection to a patient or family
- Pediatric cases
- Medical errors
- First death experience
- Unexpected patient demise



# DISCLOSURE TO PATIENTS/FAMILY MEMBERS

- Work with Risk Management
- Transparency
- Includes medical errors and unexpected outcomes
- Best practices:
  - ✓ Work with claims company first
  - ✓ Lead by physician
  - ✓ Policy in place
  - ✓ Staff aware



# HUMAN ERROR.....

“We cannot change the human condition, but we can change the conditions under which humans work.”



*(James Reason - BMJ March 2000)*



- How can your event reporting system be improved?
- How might you provide support for “second victims”?
- How can your disclosure process be improved?

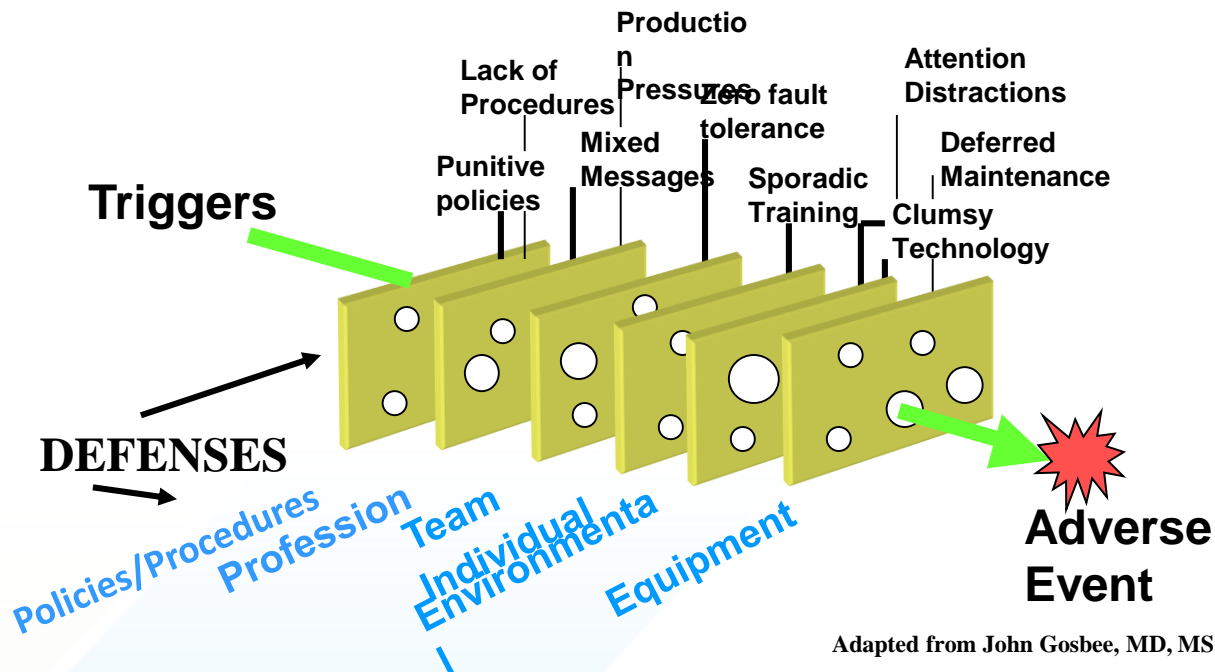


# DESIGN AND IMPROVEMENT



# MULTI-CAUSAL THEORY

## “SWISS CHEESE” DIAGRAM



Adapted from John Gosbee, MD, MS  
VA National Center for Patient Safety

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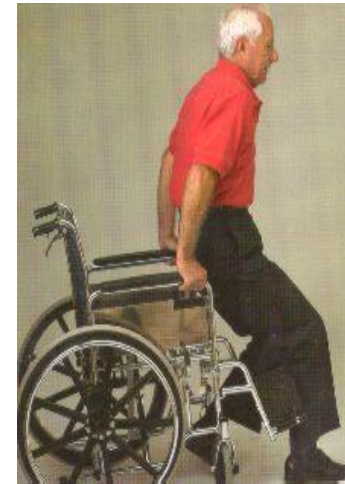
# SYSTEM DESIGN

Reliable – Is it sound and will it help decrease errors?

Scalable – can it be spread across the pharmacy?

Sustainable – Will it last over time?

# IMPROVED DESIGN



## Mistake-proofing

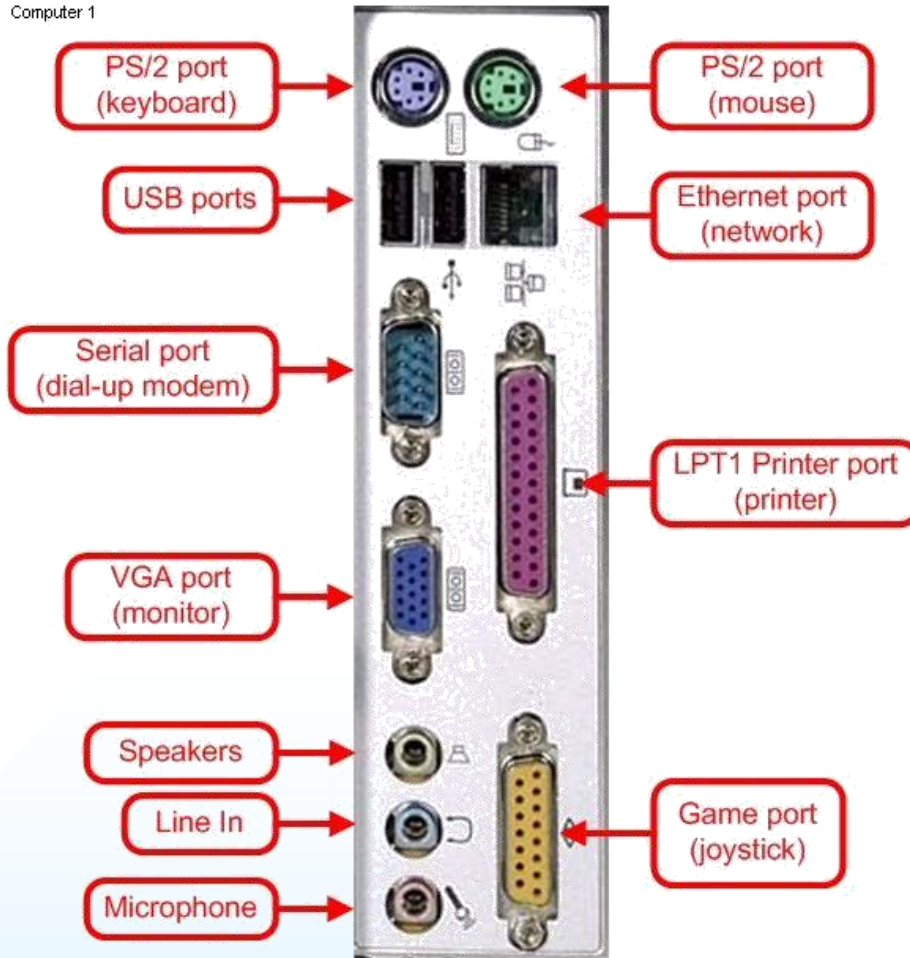
Use of process design features to facilitate correct actions, prevent simple errors, or mitigate the negative impact of errors.



## Clothes dryer stops operating when door is opened

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Computer 1



# FORCING FUNCTIONS

- A form of physical constraint
- Actions constrained so failure at one stage prevents the next step from happening
- Rely upon properties of the physical world for operation - no special training necessary

**Example: Removing potassium chloride from nursing units**



# “COUNTERMEASURES” TO HUMAN BEHAVIOR



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# EXPENSIVE ERROR PROOFING

- Bar coding
- Robots
- Technologically sophisticated examples of mistake-proofing



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# STRONGER ACTIONS



- Leadership supporting safety
- Architectural/physical changes
- Forcing functions - engineering control
- Simplify - remove unnecessary steps
- Standardize equipment
- Test new devices before purchasing

# INTERMEDIATE ACTIONS



- Checklists or cognitive aids
- Increase in staffing/decrease in workload
- Redundancy
- Enhanced communication
- Software enhancements
- Separate look and sound-a-likes
- Eliminate/reduce distractions

# WEAKER ACTIONS



- Warnings and labels
- Revised procedures and policies
- Send a memo to all
- Training
- Additional study/analysis

# MEASURE THE RIGHT THINGS

- Linked to your business drivers
- Energizes the staff to focus effort on what's important
- Gives employees the information and freedom they need to do their work



# MEASUREMENT RESULTS

Tell	Tell you what to improve
Help	Help you prioritize your focus
Become	Become a major input into your goals and strategic plan
Promote	Promote accountability
Facilitate	Facilitate continuous improvement
Satisfy	Satisfy patient/family expectations

# CHARACTERISTICS OF SOUND MEASURES





# TYPES OF MEASURES

## LAGGING:

- Outcome – output oriented
- Easy to measure
- Associated with big goals

## LEADING:

- In process – input oriented
- Influence the lagging measure



# DATA DICTIONARY

- Defines each metric
- Source of data
- Numerator and Denominator
- Exclusions
- Inclusions
- Direction arrow for “good”
- Comparisons (if available)

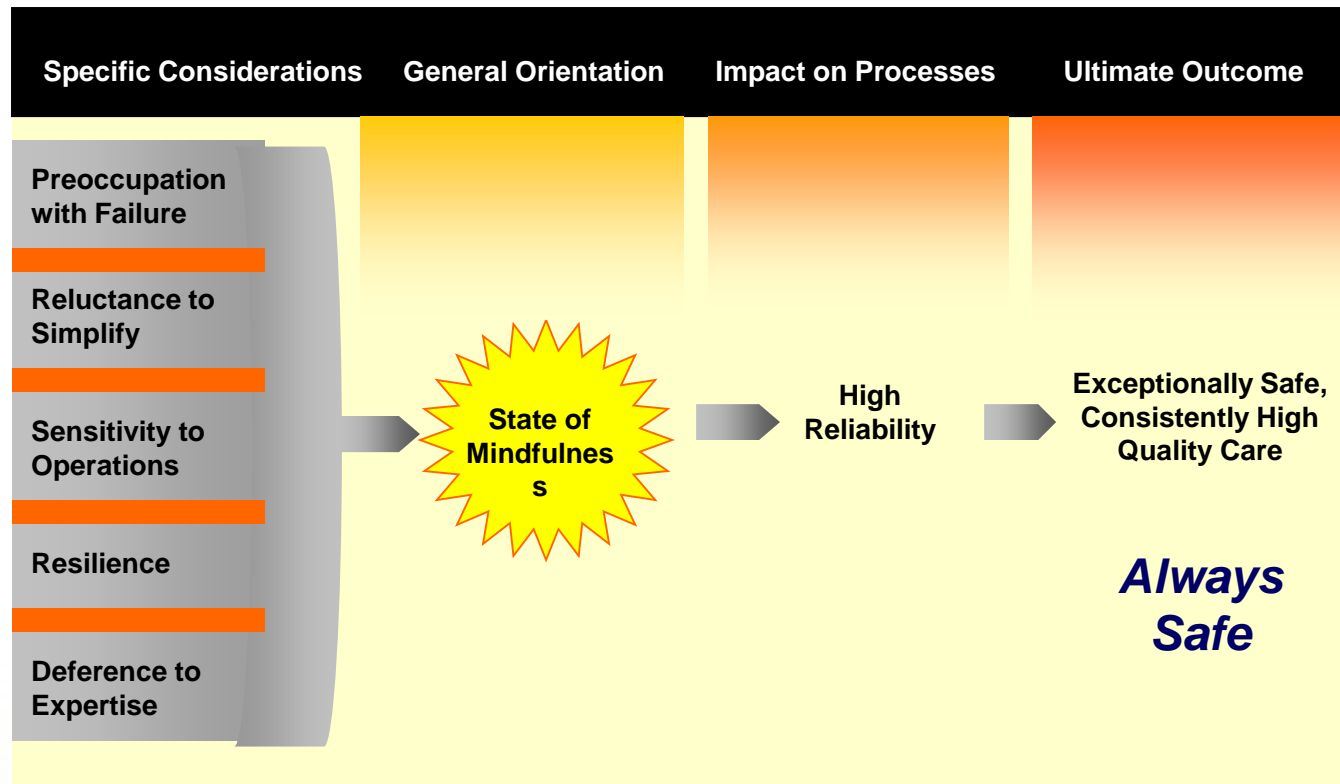


# TEAM CHARTER

## PROCESS IMPROVEMENT PROJECT TEAM CHARTER

<b>TITLE:</b>			
<b>Project Lead:</b>		<b>Facilitator:</b>	
<b>Opportunity Statement and Business Case:</b>			
<b>Scope:</b>	Work Inside Scope of Project:	Process Starting Point:	
	Out of Scope, but worthy of note:	Process Ending Point:	
<b>Goals &amp; Deliverables:</b>			
<b>Constraints:</b>			
<b>Primary Metric:</b>			
	<b>Department/Role</b>		<b>Name</b>
<b>Team members</b>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>		<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>
<b>Team Consultants:</b>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> </ul>		<ul style="list-style-type: none"> <li>•</li> <li>•</li> </ul>
<b>Key Dates:</b>	<b>Approved:</b>	<b>Planned Start Date:</b>	<b>Planned: Completion</b>

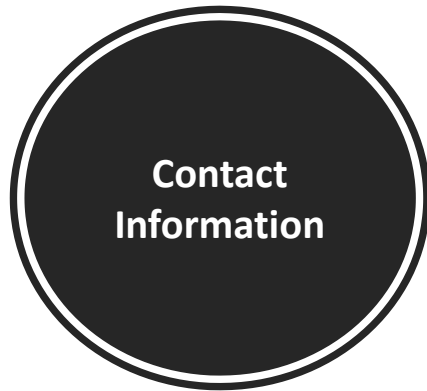
# BOTTOM LINE – STRIVE FOR HIGH RELIABILITY



- How can you improve your design processes?
- What patient safety metrics are you using?







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