A Positive Patient Safety Culture as a Path to High Reliability

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CPE Information

- Target Audience: [FOR APHA USE ONLY]
- ACPE#: [FOR APHA USE ONLY]
- Activity Type: [FOR APHA USE ONLY]

Learning Objectives

- State several barriers to transforming our health care system into a high reliability system
- List the fundamental elements of a positive patient safety culture and their application across the health care system
- Identify several tools that promote effective practice initiatives and expansion across the health care system to foster a positive patient safety culture

Self-Assessment Questions

- Medical errors may be the third leading cause of death in the U.S. (T/F)
- A fault tolerant system is not capable of functioning successfully when an error occurs. (T/F)
- Checklists are effective in developing a shared mental model for a team. (T/F)

Patient Safety is a Journey....

...and a Shared Responsibility
How is our Safety Journey Going?

- NEJM (2010)
- Health Affairs (2011)
- BMJ (2016)

Leading Causes of Death in U.S.

- Accidents: 136,053
- Resp. Disease: 147,101
- Medical Error: 251,454
- Cancer: 591,699
- Heart Disease: 614,348

Preventable medication errors

- at least 1.5 Million in the U.S. each year
- One error per hospital patient per day

Incidence and Costs

- DEATHS
  - 100,000
  - or
  - > 400,000

Costs

- $ ? billion

Wen L. 10 Things that can kill you in the hospital. The Huffington Post; April 2013.


Voice of the Patient…

- “Know me”
- “Help me”
- “Don’t Harm Me”

Why do Adverse Events Occur?

Risk

Event


Complexity in Health Care

“Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous”

- Sir Cyril Chanter

‘To Err is Human’

“We cannot change the human condition. People will always make errors and commit violations. But we can change the conditions under which they work to make these unsafe acts less likely.”

- James Reason

System Thinking:
Safer Systems for Safer Care

Error must be Managed

Fault Tolerant System - system tolerates & anticipates errors but still functions successfully…

What is High Reliability?

- Extremely well focused on preventing failure, on expecting the unexpected, and on ensuring that errors don’t result in catastrophic events
- High Risk activity but low adverse event rate

High Reliability Organizations

- Preoccupation with failure
- Reluctance to simplify
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

The success of HRO’s in managing the unexpected is their effort to act mindfully. This means that they are able to notice the unexpected in the making if they cannot halt the event, they focus on containing it, if they cannot contain it, they focus on restoration.


What does High Reliability Look Like?

- Hierarchical relationships
- Human factors
- Core work
- Standardization
- Non-punitive reporting
- Perpetual training
- Competence checked
- Leadership engaged

Aviation Culture Healthcare

- Team emphasis
- Human factors
- Core work
- Standardization
- Non-punitive reporting
- Perpetual training
- Competence checked
- Leadership engaged

Challenges and Barriers to High Reliability for Health Care

1. Human Factors
2. Leadership
3. Communication
4. Assessment
5. Physical Environment
6. Health Information Technology-related (HIT)
7. Care Planning
8. Information Management
9. Medication Use
10. Performance Improvement

Challenges and Barriers to High Reliability for Health Care...

- Culture
- Standardization
- Complexity of health care
- Industry
- Regulatory authorities
- Politics and media
- Resources
- Procurement and logistics
- Change

Path to High Reliability-VHA Model

- Safety Culture
- Just Culture
- Leadership
- High Functioning Teams
- Understand Complexity and EOC

- New Technologies
- Evidence-Based Practice
- Process Optimization and Standardization

- Electronic Medical Record
- Computer Physician Order Entry
- Medication Record, BCMA, Smart Pumps

- Evidence-Based Practice
- Understand and measure current performance
- Standardization, Simplification of Care Processes
- Default Processes with MD Exception
- Six Sigma

The Joint Commission. Most frequently identified root causes of sentinel events reviewed by the Joint Commission, 2015. https://www.jointcommission.org
Example Cases

Kimberly Hiatt Case

Eric Cropp Case

Example Cases

Meningitis Outbreak: Exserohilum rostratum

Example Cases

Just Culture

Defined

- An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information
- Individuals trust that they will not be held accountable for system failures; and are also clear about where the line must be drawn between acceptable and unacceptable behavior


Just Culture

Why Bother?

- Major barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect towards staff, residents, and patients
- Full disclosure of medical errors helps build trust with patients and their families while supporting the clinicians involved
- The just culture ensures that individuals will not be blamed or punished for reporting unsafe conditions or adverse events while holding everyone accountable for their own behavior


A Positive Safety Culture

Open

Just

Report

Learn

Inform

http://www.cdc.gov/PHIL/Photo: James Gathany

http://www.oneandonlycampaign.org/sites/default/files/upload/pdf/SIPC_insulinpen_BeAware_11x17_0.pdf

http://www.patientsafetyfirst.nhs.uk

http://www.patientsafetyfirst.nhs.uk
Just Culture

Driving Forces

- Staff satisfaction surveys suggest that frontline staff do not really understand what a non-punitive reporting system means
- Supervisory staff were unequipped to address errors in a non-punitive way because most had been educated and socialized within the old model of error management and reporting
- Employees disciplined using a punitive approach without the full benefit of a systems analysis


Just Culture

Response

- Response to error is based on the type of behavior associated with the error
  - Human error
    - slips, lapse, mistake
  - At-risk behavior
    - taking shortcuts
  - Reckless behavior
    - ignoring required safety steps

Managing Behaviors Tool

<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadvertent action: slip, lapse, mistake</td>
<td>A choice: risk not recognized or believed reasonable</td>
<td>Conscious disregard of unreasonable risk</td>
</tr>
<tr>
<td>How to Manage?</td>
<td>How to Manage?</td>
<td>How to Manage?</td>
</tr>
<tr>
<td>Learn</td>
<td>Learn</td>
<td>Learn</td>
</tr>
<tr>
<td>Console</td>
<td>Coach</td>
<td>Punish</td>
</tr>
</tbody>
</table>


Communication Tool

- Effective Fellowship Algorithm
  - Engage Team
  - Take Action
  - Make Point
  - Documentation

Feedback

SHOULD BE: Specific, More Open, Direct Point
AVOID: Full and Open Communication

The Error Management Pyramid

- Mitigate Error
- Avoid Error
-trap Error

Just Culture
Immediate Reporting
Standardized Procedures
Closed Loop Communication
Redundant Double Check
Time Out
Team Monitoring & Crosschecking

Briefing
Debriefing
Checklist
Inquiry & Advocacy
Standardization
Fatigue Management
High Reliability Team Behaviors

- Situational Awareness
- Closed Loop Communication
- Standardized Communication
- Shared Mental Model
- Rule-Based decision making

Situational Awareness

- Countermeasures
- Acknowledgements
- Algorithms / Tools
- Checklists / Algorithms
- Briefings

Situation Awareness Threat Management

- Red Flags
  - Conflicting input: Two things that should agree don't agree
  - Confusion: "This doesn't make sense"
  - Not Following Policy: Operating outside of established policy
  - Failure to Meet Targets: Expectations after an intervention are not met
  - Not Communicating: People on the teams stop talking - obvious tension - no one saying anything

1-2-3 Rule

1. Step Back
2. Analyze
3. Use Resources

Checklist Use

Checklist Use

Human Factors Targets

- Environment
- Physical Demands
- Product Design
- Teams

- Distractions
- Mental Workload
- Systems
- Physical Demands
- Product Design

Heuristic Evaluation Tool

- Step 1: Identification of Usability Issues
  - Contextual Issues
  - Cognitive Issues
  - Technical Issues
  - Organizational Issues

- Step 2: Analysis of Usability Issues
  - Impact on User Experience
  - Impact on System Performance

- Step 3: Recommendation of Solutions
  - Design Changes
  - Training Programs
  - User Manuals

Patient Safety Strategic Road Map

- What Did Happen?
- What Should Have Happened?
- What Can Change?
- What Did We Learn?
Strategic Road Map-Auto Example

Key Points

- A Positive Patient Safety Culture is the Path to High Reliability in Health Care
- ‘To err is Human’
- Challenges and Solutions:
  - Human Factors
  - Leadership
  - Communication
- Leadership is critical to success
- Focus on sustainment
- The journey is long

Know Safety No Harm

Answers To Self-Assessment Questions

- Medical errors may be the third leading cause of death in the U.S. (True)
- A fault tolerant system is not capable of functioning successfully when an error occurs. (False)
- Checklists are effective in developing a shared mental model for a team. (True)

Closing Remarks

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