Getting to Zero: Summary

The 2015 Northwest Patient Safety Conference included a short presentation on adverse events in Washington State, with a focus on a persistent “non-zero” rate of surgical-related adverse events. The presentation was followed by table discussion of two questions to attendees:

- If it were up to you, what would you do differently [to get to zero]?
- In your estimation, what is keeping that from happening?

The following are themes derived from 30 written responses, representing participants from across the health care system, with selected specific examples.

If it were up to you, what would you do differently?

Culture and leadership

- Hire and coach leadership who do not accept simple explanation such as “communication issue.”
- Have senior leadership who are involved in/passionate about safety.
- Seek to understand why people do not follow guidelines.
- Encourage staff to be accountable and take ownership.
- It must start at the top: the Board and C-suite must support and model a safety culture.

Technical/process supports

- Consider scribes for physicians in Emergency Departments and Operating Rooms; for nurses to spend more time with patient.
- Set up systems to assure that steps are not based on memory; e.g., use checklists and other tools and techniques that have been shown to work.
- More commitment to Lean methodology to increase standardization and decrease variation.

Communication

- Focus on how to improve interpersonal communication differences.
- Encourage and empower staff and give them the tools to speak up when they have concerns, to feel safe in doing so.
- Promote full communication/participation – so that a student in the room truly has the same voice as the surgeon.
- Provide communication training for all staff.
- Improve transparency at all levels regarding adverse events: if one occurs on one unit, staff across the entire organization should know about it.

Root cause analysis processes

- Bring in other departments to provide valuable input to the RCA.
- Document a complete action plan with a timeline and hold everyone to it.
- After RCAs are complete, ensure accountability of action owners: have a designated employee whose position it is to facilitate/assist with that work.
- Involve patient/family in the RCA process.

What is keeping that from happening?

Culture

- Lack of organizational commitment, involvement from leadership; C-suite does not listen to the front line.
- A push for productivity and throughput
- Staff are punished for making changes or speaking up; fear of reprisal.
- Process owners and affected leaders are not held accountable to outcomes.
- Lack of follow-through from senior leadership.
- Fear: of reprisal, bad publicity.
- Physicians communicating that they ‘are in control,’ others ‘don’t know anything.’

Resources

- Time; money for training; staffing; concerns about productivity and revenue.