Patient Safety: Building a Culture of Respect and Accountability

Our journey at Franciscan Health System in Perioperative Services

Washington Patient Safety Coalition

September 19, 2013

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Objectives today

- Identify challenges related to developing a patient-centric safety culture
- Discuss the elements of a patient safety culture
- Describe strategies for creating cultural change

Key Drivers

- Recent sentinel events across the system last 18 months
- Regional surgical physician leadership team
- Senior leadership support, presence
- CMO presence at each session
- Who was required to be there—which providers, mid levels—correct list/contacts
- Consequences of not attending clear
- Key information, variety of presentation formats

Safety Summit

FHS Perioperative Services
October-November 2012

Mandatory Safety Summit Meetings in October

Join us for an open and honest discussion on how to improve the quality of care we provide to further enhance our patient safety culture.

Our sessions will result in a defined safety path that sets clear expectations for providing the safest care possible in our surgical settings throughout Franciscan Health System.

Attendance is **mandatory** at one of the following meetings. Choose a summit event to attend:

Oct. 3: **St. Clare Hospital**
Resource Center Conference Room
6:30am-8:30am*; 5:30pm-7:30pm

Oct. 10: **St. Francis Hospital**
MOB Conference Room
6:30am-8:30am*
St. Joseph Medical Center
Lagerquist A&B, 5:30pm-7:30 pm

Oct. 15: **St. Joseph Medical Center**
Lagerquist A&B
6:30am-8:30am; 5:30pm-7:30pm

Oct. 16: **St. Clare Hospital**
Resource Center Conference Room
1:00pm-3:00pm

Oct. 17: **St. Anthony Hospital**
Smalling Conference Room
6:30am-8:30am*; 5:30pm-7:30pm

Oct. 18: **St. Francis Hospital**
MOB Conference Room
6:30am-8:30am

Oct. 23: **St. Francis Hospital**
MOB Conference Room
5:30pm - 7:30pm

Oct. 24: **St. Anthony Hospital**
Smalling Conference Room
12:00pm-2:00pm

Oct. 25: **St. Francis Hospital**
MOB Conference Room
6:30am-8:30am; 12:00pm-2:00pm

Oct. 29: **St. Elizabeth Hospital**
Rainier Conference Room
6:30am-8:30am; 5:30pm-7:30pm

Oct. 30: **St. Joseph Medical Center**
Lagerquist A&B
6:30am-8:30am; 12:00pm-2:00pm

Oct. 31: **St. Joseph Medical Center**
Lagerquist A&B
6:30am-8:30am*; 5:30pm-7:30pm

Due to limited seating at each session, you will be required to register in advance. Please e-mail Tammy Dobson, Periop Project Manager, at tammydobson@fhshealth.org or call and leave a reservation at 253-426-6509. Please be sure you register yourself and any of your assistants that come into the operating room.

**Includes a 0915 surgery start time in hospital OR that day*

CATHOLIC HEALTH INITIATIVES
Franciscan Health System

Goals for today

- Providing a safe surgical environment 100% of the time
- Being an actively engaged member of the surgical team every single time (trust, respect, focus, behavioral standards, etc)
- Creating clear understanding and standardization of safety measures to support the surgeon-led Surgical Checklist, Universal Protocol and Prevention of Retained Objects
- Reinforcing 100% accountability by holding each other accountable for behavior and compliance—not just self
- Creating a duty a speak up and say “STOP” when standards are violated or a safety concern is recognized

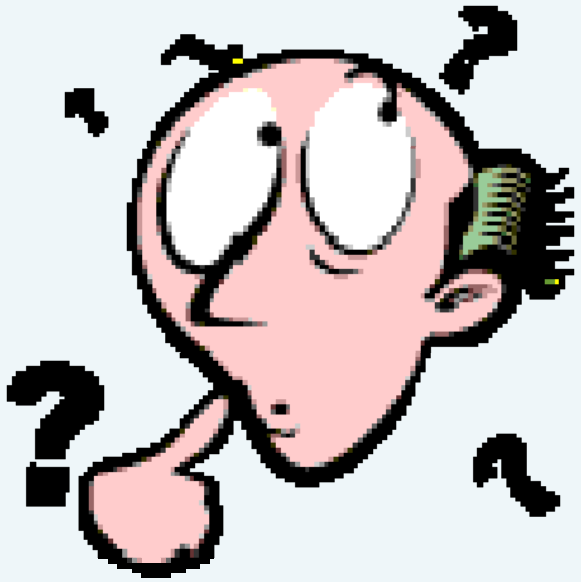
Agenda

- Interviews on safety
- What is a culture of safety?
- Universal Protocol/ Surgical Checklist Video
- Team behaviors for prevention of retained objects

Round Table Discussion questions

- Wrap up and next steps

What *is* a Culture of Safety?



Institute of Medicine (IOM) Report 1999

To Err Is Human: Building a Safer Health System

- 98,000 patients die each year as a result of preventable medical errors
- Main conclusions
  - Majority of medical errors did not result from a “bad apple” problem
  - Errors are caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them

Type of Sentinel Event	2004 -1Q 2012 Total	2010	2011	1Q 2012
Abduction	24	1	1	1
Anesthesia-Related Event	87	6	16	0
Criminal Event	251	28	49	14
Delay In Treatment	716	95	138	33
Dialysis-Related Event	8	2	1	1
Elopement	71	14	8	2
Fall	477	56	96	15
Fire	88	8	15	5
Infant Discharge to Wrong Family	2	1	0	0
Infection-Related Event	146	14	20	5
Inpatient Drug Overdose	63	8	19	2
Maternal Death	99	16	18	0
Med Equipment-Related	178	25	39	2
Medication Error	345	44	45	9
Op/Post-op Complication	655	86	133	19
Other Unanticipated Event****	379	38	71	13
Perinatal Death/Injury	209	31	36	6
Radiation Overdose*	27	8	8	0
Restraint Related Event	112	5	15	2
Self-Inflicted Injury	43	7	6	2
Severe Neonatal Hyperbilirubinemia*	4	2	1	0
Suicide	620	67	131	20
Transfer-Related Event	23	3	7	2
Transfusion Error	100	5	20	2
Unintended Retention of a Foreign Body*	700	133	188	42
Utility System Failure	6	0	2	0
Ventilator Death	39	6	8	1
Wrong–patient, wrong-site, wrong-procedure	846	93	152	27
Total Incidents Reviewed	6318	802	1243	225

Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)

2010 (N=802)		2011 (N=1243)		1Q 2012 (N=225)	
Leadership	710	Human Factors	899	Human Factors	157
Human Factors	699	Leadership	815	Leadership	153
Communication	661	Communication	760	Communication	138
Assessment	555	Assessment	689	Assessment	136
Physical Environment	284	Physical Environment	309	Information Management	50
Information Management	226	Information Management	233	Physical Environment	48
Operative Care	160	Operative Care	207	Operative Care	27
Care Planning	135	Care Planning	144	Medication Use	21
Continuum of Care	112	Continuum of Care	137	Continuum of Care	17
Medication Use	86	Medication Use	97	Care Planning	15

The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

What makes communication tools so important?

- Someone may know there is a problem, but can't get everyone on the same page
- The environment in which we work has become increasing complex
- Situational overload—faulty memory and distractions are a particular danger
- Easy to skip steps especially on routine processes

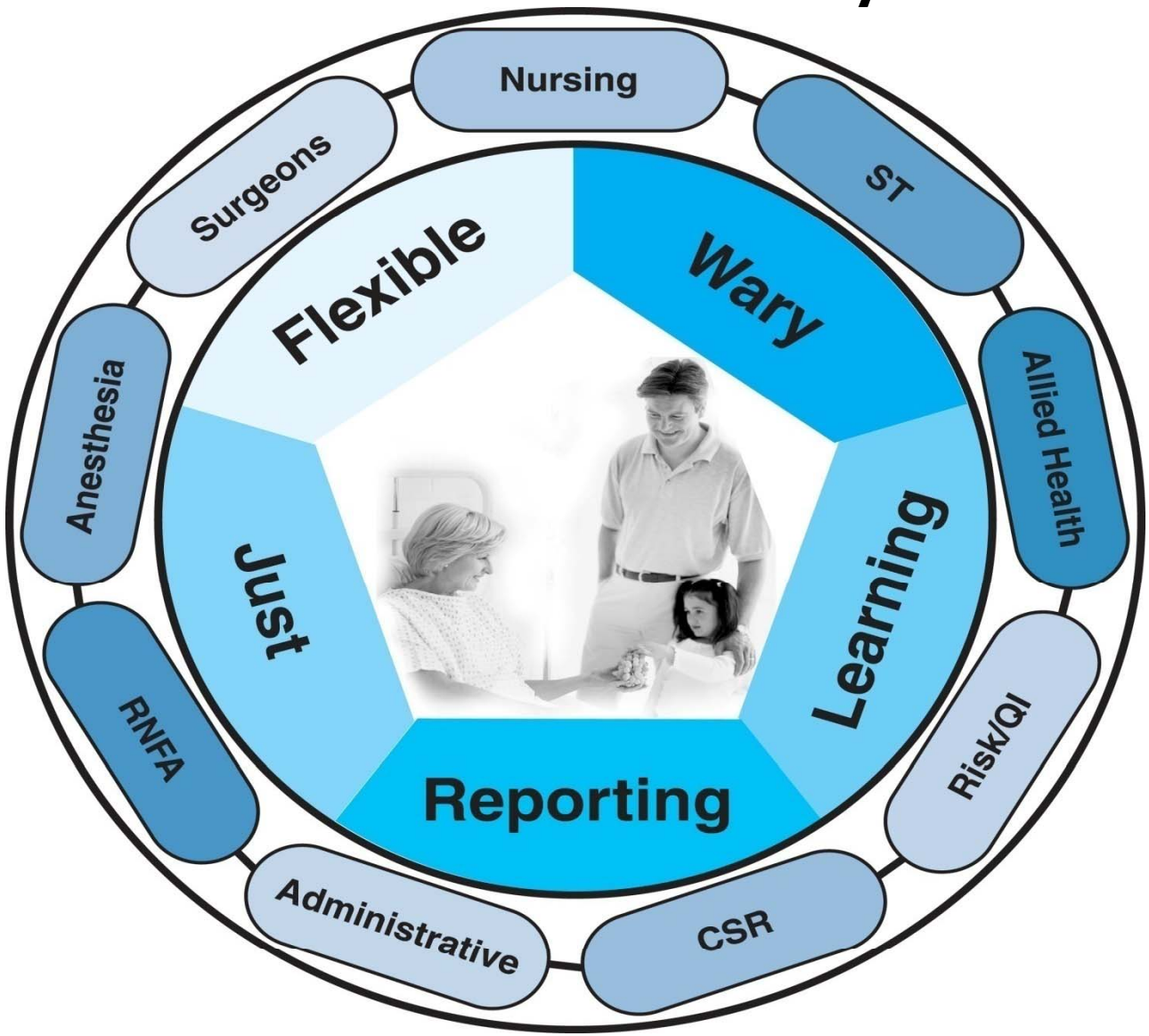
Increasing need for communication tools, such as SBAR, checklists, to help consistency

Silence Kills…..©2005

1. Competence 50-80%
2. Work Ethic 75%
3. Lack of Support 20%
4. Disrespect 75%
5. Micromanagement 50%
6. Broken Rules 85%
7. Mistakes 49-85%

http://www.silencekills.com/

Patient Centric Safety Culture



Reporting Culture

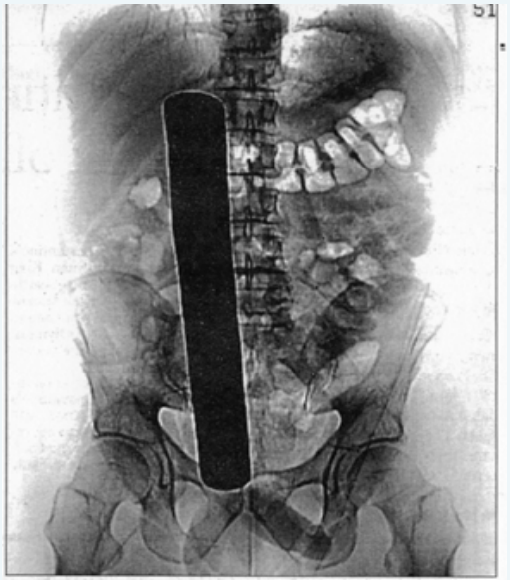
- Focus on both actual events *& near misses , safety concerns*
- Transparency & Open Discussion
- Easy Documentation System
- Rounds that focus on Individual Cases that Provide Learning
- Plan/Do/Check/Act in responding to reported concerns

Wary Culture

- Go *looking for trouble;* conduct walk-arounds in all areas
- Preoccupied with Opportunities for Improvement
- Being vigilant is a healthy state
- Any given moment an untoward event can occur

Healthy reporting, learning, & flexible cultures foster a wary culture

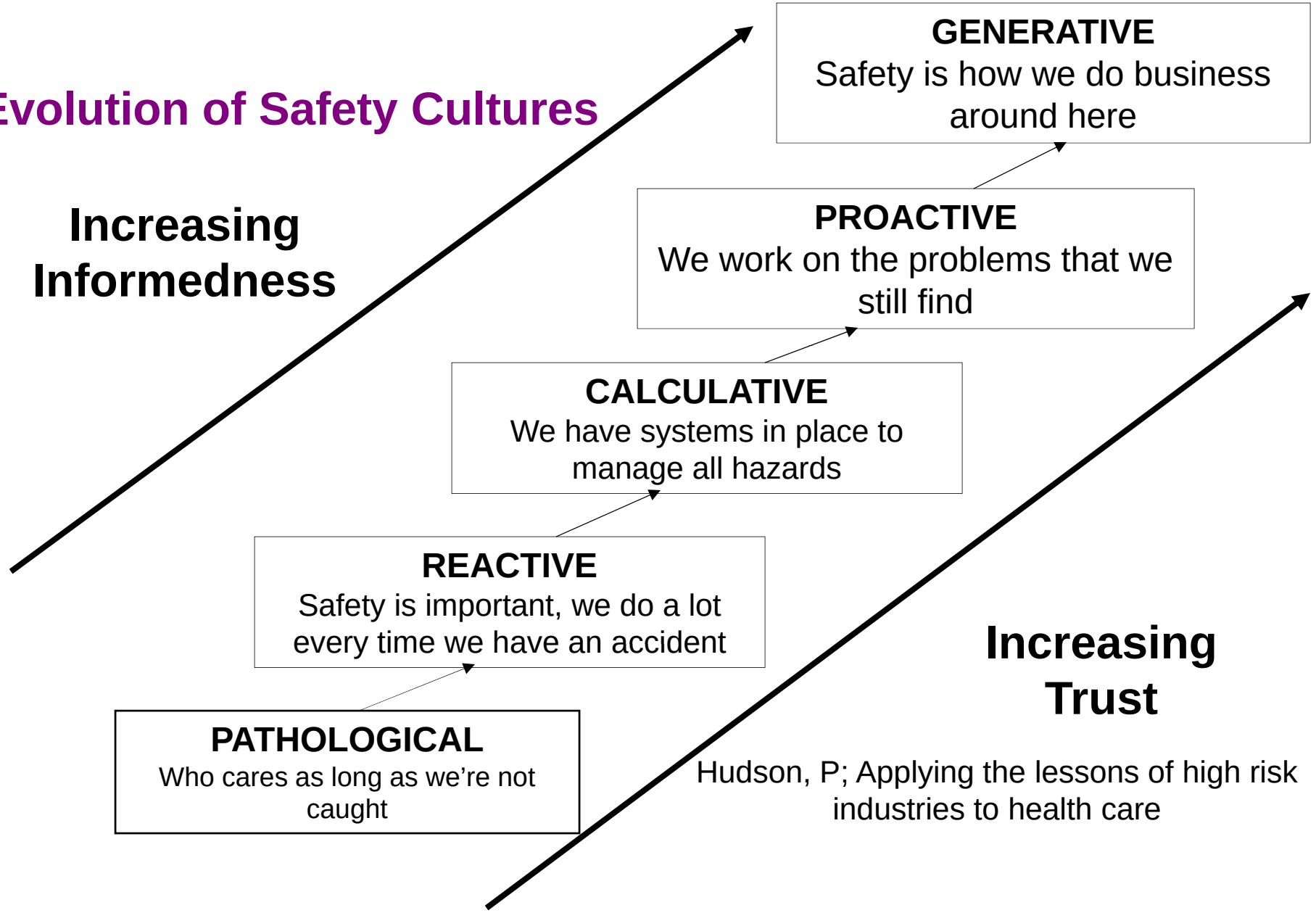
Normalization of Deviance -- “drift”



- Individuals or teams repeatedly accept lower standards of performance until the lower standard becomes the norm.
- Complacency
- Nothing has happened to us so far.

Influencing Accountability

Evolution of Safety Cultures



Hudson, P; Applying the lessons of high risk industries to health care

Questions to discuss:

How would you rate our culture of safety? What are key elements?

What keeps us from speaking up?

Next---

- Universal Protocol and Surgical Checklist—standard approach for FHS

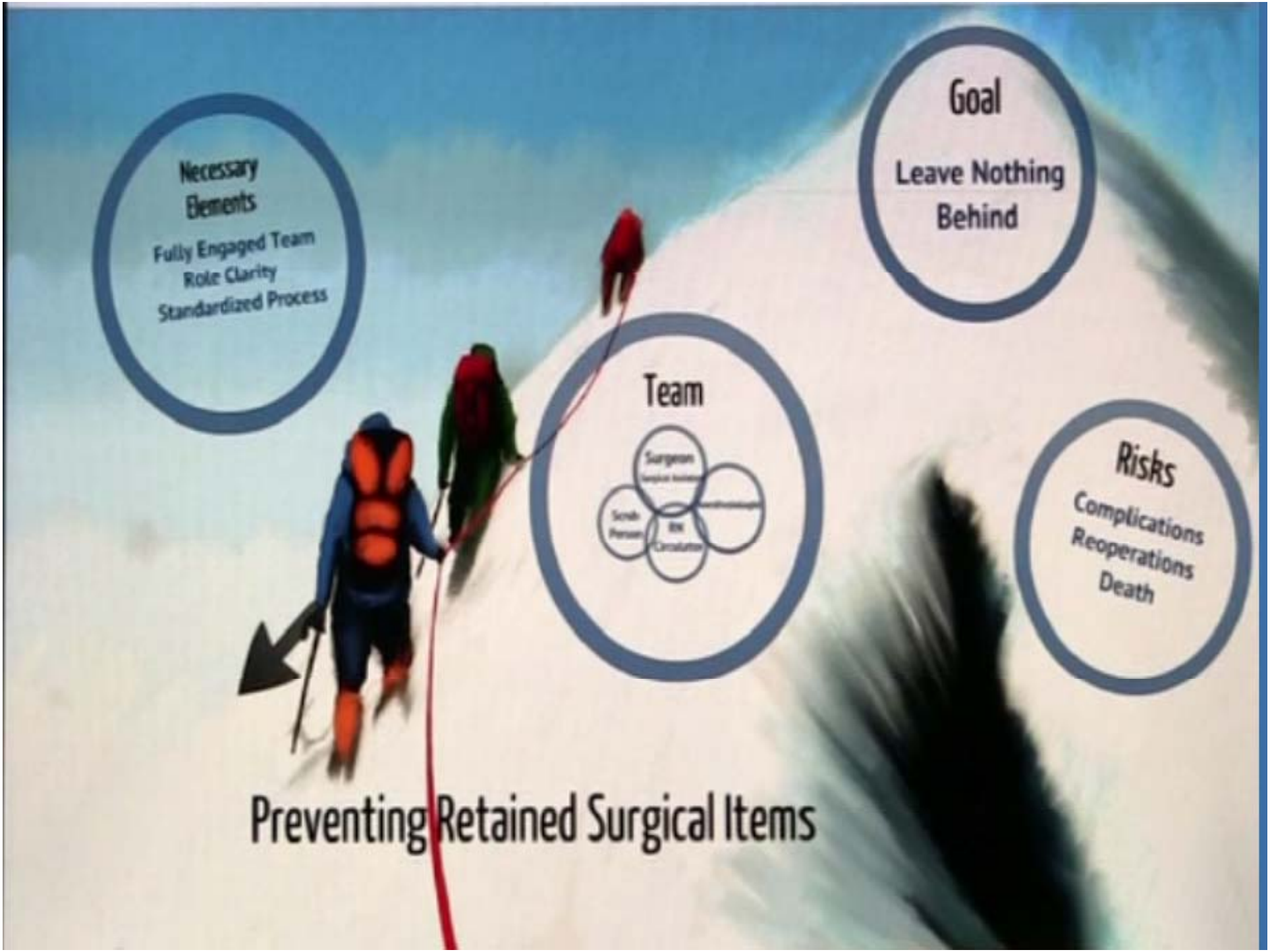
FHS film reviewing UP elements, policy, how NOT to do the checklist, and how to do the checklist

Please discuss:

- What keeps us from performing the universal protocol elements and the Surgical Safety Checklist as intended?

Next

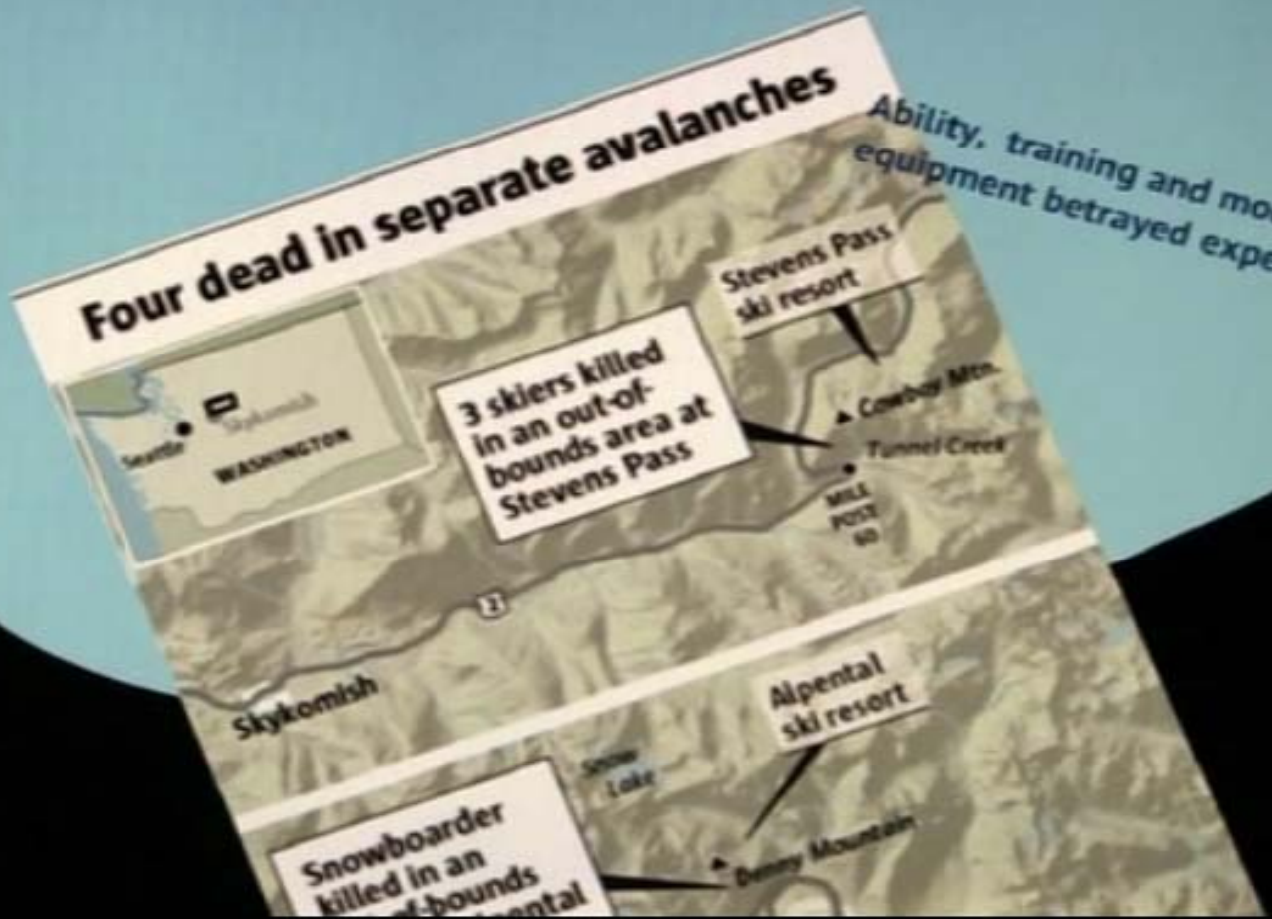
- Prevention of Retained Foreign Objects—standard approach for FHS


Necessary Elements
Fully Engaged Team
Role Clarity
Standardized Process
Goal
Leave Nothing Behind
Team
Surgeon
Risks
Complications
Reoperations
Death
Preventing Retained Surgical Items

Situational Awareness

All team members continually aware of the unexpected

Experience and Skill Are No Guarantee of Safety




Use the Tools
Work Together
Return from the Summit Safely

For Discussion:

- What keeps us from performing as a team in preventing retained objects?
- What are other routine processes that we don't follow carefully?

To wrap up:

"Cognizant organizations understand the true nature of the "safety war." They see it for what it really is –a long guerilla struggle with no final conclusive victory. For them, a lengthy period without a bad accident does not signal the coming of peace. They see it, correctly, as a period of heightened danger and so reform and strengthen their defenses accordingly. …The conclusion of the safety war might be likened to the last helicopter out of Saigon rather than a decisive Yorktown, Waterloo, or Appomattox….If eternal vigilance is the price of liberty, then chronic unease is the price of safety." James Reason

- From Internal Bleeding, Robert Wachter, MD and Kaveh Shojania, M.D. , p. 50

Culture of Safety – Team Member Commitment

Mission Statement

To establish that patient safety is the priority by everyone at every level in Franciscan Health Perioperative Services.

Commitment

As a member of the FHS Perioperative Services team, I commit to being personally responsible for safety as demonstrated by:

- *Consistent use of safety measures for all patients*
- *Holding myself and others accountable to ensure safety requirements are followed at all times*
- *Collaborating with all team members to consistently implement practices that improve safety in Perioperative Services*

*Team Member Signature*_____ *Date*_____

Safety Summit Evaluation

Date attended: _____ Title: _____ (ST, MD, RN, etc…)

Statement	Definitely No	Somewhat No	Neither	Somewhat Yes	Definitely Yes
Were the objectives of the summit met?	1	2	3	4	5
Did the presentations increase your understanding of safety in the surgical arena?	1	2	3	4	5
Did the presentations clarify your role in ensuring safety in the surgical arena?	1	2	3	4	5
Were the sessions designed to foster a sense of team or collaboration?	1	2	3	4	5
In planning future summits, did the time of day and multiple sessions provide good options with your schedule?	1	2	3	4	5

What topics would you like in future safety summits?

What did you like most about the summit?

What did you like least about the summit?

Would you like to volunteer to be part of an upcoming safety council? _____Yes _____No
If Yes, please provide your contact information: Name_____Title_____
Email_____

Attendance

- 21 Total Sessions Conducted
- As of 11/15 – 1032 staff members, surgeons and PA's had registered
- 478 surgeons and PA's were notified of the requirement to attend a session
- 46 of those 478 have either retired, or are no longer with FHS
- 5 of the 478 were excused from attending a session due to medical leave, vacation, etc
- 37 of the remaining 427 did not attend a session of 11/15

Since then:

- **Site based Safety Councils**
- **Orientation/Onboarding Monthly**

Safety 2.0:

- **Team training—CRM?**
- **Interdisciplinary education—how often? What topics? Online/simulation? Measures of effectiveness?**
- **Other service lines?**

Questions?

- What strategies have you used?
- What training have you found successful?
- What has been successful in reaching physicians consistently?

Thank you for your interest in creating a safe patient culture!