Building a Culture of Safety and Continuous Learning

Michael Leonard, MD
Hospital Council of Northern and Central California
The Profile of Safety & Quality Leaders

Superior safety / quality and operational efficiency is their non-negotiable core value

Leadership engagement and accountability - senior and clinical, safe & just culture

Cultural work – actionable cultural metrics, teamwork & communication, environment of respect

Transparency of clinical data and process

Reliable processes of care

Learning organization - systematic flow of information, feedback, continuous process improvement
Evolution of A Culture of Safety and Reliability

- **PATHOLOGICAL**: Who cares as long as we’re not caught *Chronically Complacent*

- **REACTIVE**: Safety is important. We do a lot every time we have an accident

- **CALCULATIVE**: We have systems in place to manage all hazards

- **PROACTIVE**: Anticipating and preventing problems before they occur

- **GENERATIVE**: Safety is how we do business around here

*Adapted from Safeskies 2001, “Aviation Safety Culture,” Patrick Hudson, Centre for Safety Science, Leiden University*
The Critical Role of Effective Leadership
Effective Leadership

With regard to quality and safety work, the most important factor in predicting success was the quality of leadership and the organizational culture (Krause)

Organizations highly successful in safety were also generally successful in operational performance (Krause)

Clear commitment of senior and clinical leaders to quality and safety efforts is essential

Effective leaders define very clear behaviors that create value for the patient, clinicians and the organization. They model these behaviors, and have “one set of rules”, i.e. they apply to everyone.

There is engagement at all levels of the organization
Being a Jerk is Not OK - It’s Dangerous
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.

Amy Edmondson
In this clinical area, it is difficult to speak up if I perceive a problem with patient care.

Note: Use the multicolored bars to see how you fit with the benchmark archive. If you have less red and more green than the benchmark, you are more positive than the benchmark. If the colors all match up, you are about the same as the benchmark.
Culture of Safety

No one is ever hesitant to voice a concern about a patient

Caregivers - capable, conscientious and playing by the rules - feel comfortable to speak up regarding errors, near misses and adverse events

When people do speak up, they have a high degree of confidence that the organization will act on their concerns and demonstrate such.

There is a cyclic flow of information that leads to analysis, action and feedback - a learning organization - to reinforce well defined behaviors and values
The Importance of Reducing Variation and Avoiding Avoidable Harm
Avoiding Avoidable Harm is Key for Success

Never Events - retained surgical objects, transfusion injury, etc.

Healthcare Associated Infections

The current rate of adverse and avoidable harm is unacceptable

Quality and safety will have progressively more financial impact - more metrics
Evolution of Risk Mitigation

No Preventable mortality - HSMR, sepsis, rapid response, etc.

No preventable harm - Triggers, AE

- Baylor 30% patients with positive trigger / 6% patients adversely affected or increased LOS

- North Carolina study - 10 hospitals, 25% patients experienced harm - 60% “avoidable”

- Health Affairs - 1/3 patients experienced avoidable harm, 2/3 “avoidable”

No preventable risk
Computerized Surveillance of Adverse Drug Events in Hospital Patients

David C. Classen, MD; Stanley L. Pestotnik, RPh; R. Scott Evans PhD; John P. Burke, MD

Objective.—To develop a new method to improve the detection and characterization of adverse drug events (ADEs) in hospital patients.

Design.—Prospective study of all patients admitted to our hospital over an 18-month period.

Setting.—LDS Hospital, Salt Lake City, Utah, a 520-bed tertiary care center affiliated with the University of Utah School of Medicine, Salt Lake City.

Patients.—We developed a computerized ADE monitor, and computer programs were written using an integrated hospital information system to allow for multiple source detection of potential ADEs occurring in hospital patients. Signals of potential ADEs, both voluntary and automated, included sudden medication alert orders, antidote ordering, and certain abnormal laboratory values. Each day, a list of all potential ADEs from these sources was generated, and a pharmacist reviewed the medical records of all patients with possible ADEs for accuracy and causality. Verified ADEs were characterized as mild, moderate, or severe and as type A (dose-dependent or predictable) or type B (idiopathic or allergic) reactions, and causality was further measured using a standardized scoring method.

Outcome Measure.—The number and characterization of ADEs detected.

Results.—Over 18 months, we monitored 36,653 hospitalized patients. There were 731 verified ADEs identified in 648 patients, 701 ADEs were characterized as moderate or severe, and 66 were classified as type A reactions. During this same period, only nine ADEs were identified using traditional detection methods. Physicians, pharmacists, and nurses voluntarily reported 62 of the 731 ADEs detected using this automated system. The other 669 ADEs were detected from automated signals, the most common of which were digoxin, hydralazine, hydrocortisone, and mexitron hydrochloride, use, high serum drug levels, leukopenia, and the use of phenelzine and antidiuretics. The most common symptoms and signs were pruritus, nausea, and vomiting, rash, and conduction delay/lethargy. The most common drug classes involved were analgesics, anti-infectives, and cardiovascularr agents.

Conclusion.—We believe that screening for ADEs with a computerized hospital information system offers a potential method for improving the detection and characterization of these events in hospital patients.

From the Department of Clinical Epidemiology, LDS Hospital, Salt Lake City, Utah, and the Division of Infectious Disease, University of Utah School of Medicine, Salt Lake City.

Reprint requests to Department of Clinical Epidemiology, LDS Hospital, 801 South Medical Drive, Salt Lake City, UT 84143 (David C. Classen, MD).

JAMA, November 27, 1991—Vol 266, No. 20

AS MANY AS 50% of hospitalized patients may experience an adverse drug event (ADE) during their hospital stay, according to current estimates. Moreover, fatal ADEs are expected in approximately 0.3% of hospitalized patients (50,000 to 140,000 patients annually) in the United States. Adverse drug events lead to 2% to 5% of all hospital admissions each year, and one recent report found that complications from drug therapy were the most common adverse events in hospitalized patients.

For editorial comment see p 2878.

The exact costs attributed to ADEs are unknown, but it has been suggested that ADEs can prolong hospital stays and add to health care expenditures. Studies have indicated that hospitalized patients who are exposed to more than 16 different drugs during their hospitalization have a 0.5% probability of experiencing an ADE. Patients who have experienced a true ADE are two to three times more likely to experience another subsequent event than patients who have not had an ADE. In addition, hospitalized patients are often elderly and have underlying, comorbid conditions that impair their ability to distribute, metabolize, and excrete drugs, and these elderly patients are more likely to experience toxic reactions. Clearly, hospitalized patients have multiple risk factors predisposing them to ADEs. For these and other reasons, ADE detection and reporting systems have been advocated. The need for hospitals to assume a more active role in ADE surveillance has been addressed both nationally and internationally. The World Health Organization, the US Food and Drug Administration (FDA), and the Joint Commission on Accreditation of Healthcare Organizations have all addressed this need. The
## ADE Detection at LDS Hospital

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>Automated Detection</th>
<th>Enhanced Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>9</td>
<td>641 (88%)</td>
<td>90 (12%)</td>
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</table>

*Total - 731*
Large-scale deployment of the Global Trigger Tool across a large hospital system: refinements for the characterisation of adverse events to support patient safety learning opportunities

V S Good, M Saldaña, R Gilder, D Nicewander, D A Kennerly

Background: The Institute for Healthcare Improvement encourages use of the Global Trigger Tool to objectively determine and monitor adverse events (AEs).

Setting: Baylor Health Care System (BHCS) is an integrated healthcare delivery system in North Texas. The Global Trigger Tool was applied to BHCS’s eight general acute care hospitals, two inpatient cardiovascular hospitals and two rehabilitation/long-term acute care hospitals.

Strategy: Data were collected from a monthly random sample of charts for each facility for patients discharged between 1 July 2006 and 30 June 2007 by external professional nurse auditors using an MS Access Tool developed for this initiative. In addition to the data elements recommended by Institute for Healthcare Improvement, BHCS developed fields to permit further characterisation of AEs to identify learning opportunities. A structured narrative description of each identified AE facilitated text mining to further characterise AEs.

Initial findings: Based on this sample, AE rates were found to be 68.1 per 1000 patient days, or 50.8 per 100 encounters, and 39.8% of admissions were found to have ≥1 AE. Of all AEs identified, 61.2% were hospital-acquired, 10.1% of which were associated with a National Coordinating Council — Medical Error Reporting and Prevention harm score of “H or I” (near death or death).

Concurrent with the launch of the “5 Million Lives Campaign”, the Institute for Healthcare Improvement (IHI) encouraged broad use of the Global Trigger Tool (GTT) for measuring adverse events (AEs) as a means to objectively determine and monitor patient harm that occurs throughout the healthcare system. Although the concept of “trigger tools” to focus medical record reviews and identify AEs was introduced in 1974,1 most institutions continue to rely on voluntary reporting and traditional record reviews to quantify AEs.2 Although these methods provide valuable information regarding some aspects of patient safety, they have substantial inherent limitations: comprehensive manual chart reviews are expensive and time-consuming3; computerised searches of electronic records are quicker and less expensive but, depending on the sophistication of the search strategy, may miss documented events that have been described without using the selected search terms4; and voluntary reporting systems have been found to grossly underestimate the true rate of AEs5 6 and to predominantly capture “near-miss” reports.7 More recently, trigger tools have emerged...
ADVERSE EVENTS IN HOSPITALS: OVERVIEW OF KEY ISSUES
‘Global Trigger Tool’ Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured

**ABSTRACT** Identification and measurement of adverse medical events is central to patient safety, forming a foundation for accountability, prioritizing problems to work on, generating ideas for safer care, and testing which interventions work. We compared three methods to detect adverse events in hospitalized patients, using the same patient sample set from three leading hospitals. We found that the adverse event detection methods commonly used to track patient safety in the United States today—voluntary reporting and the Agency for Healthcare Research and Quality’s Patient Safety Indicators—fared very poorly compared to other methods and missed 90 percent of the adverse events. The Institute for Healthcare Improvement’s Global Trigger Tool found at least ten times more confirmed, serious events than these other methods. Overall, adverse events occurred in one-third of hospital admissions. Reliance on voluntary reporting and the Patient Safety Indicators could produce misleading conclusions about the current safety of care in the US health care system and misdirect efforts to improve patient safety.

Improving patient safety continues to be a priority for both policy makers and health care providers in the United States. As a result, during the ten years since the publication of the Institute of Medicine’s landmark report, *To Err Is Human: Building a Safer Health System*, there have been numerous initiatives to improve the safety of patient care in the United States. Several studies have reported on the often resource-intensive interventions intended to improve the safety and reliability of care in the highly fragmented US health care system. Many health care organizations have also used their own internally reported sentinel events to measure the safety of their system.

This focus on sentinel events has been encouraged by the adoption of reporting patient safety “never events” (events that should not have happened; for example, deaths from blood transfusions) in several states. The Joint Commission’s Sentinel Event Policy of 1996 and the Patient Safety and Quality Improvement Act of 2005 encourage further development of such volum-
### EXHIBIT 4

#### Adverse Event Detection, By Severity Level And Hospital

<table>
<thead>
<tr>
<th>SEVERITY LEVEL</th>
<th>IHI Global Trigger Tool</th>
<th>AHRQ Patient Safety Indicators</th>
<th>Hospital voluntary reporting system</th>
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<td>I</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
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<td><strong>35</strong></td>
<td><strong>4</strong></td>
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</table>

<table>
<thead>
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<th>HOSPITAL</th>
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<th>AHRQ Patient Safety Indicators</th>
<th>Hospital voluntary reporting system</th>
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</thead>
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<tr>
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<td>13</td>
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<tr>
<td>Hospital B</td>
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<td>101</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>354</strong></td>
<td><strong>35</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>
How to Effectively Measure Safety Culture and Apply it to Improve Care.
Using Cultural Data to Drive Improvement

The perceptions of individual caregivers at a clinical unit level are essential, as there is 5-6 times more variation there than across the hospital.

Issues of psychological safety, resolving disagreements in the best interest of the patient, fear of disclosing errors, problems with handoffs, and perceptions of leadership are all common areas of profound opportunity.

Look at the broad themes organizationally.

Use the data so front line caregivers can debrief their results, commit to action, and link it to leadership support in a measurable fashion - this is very powerful.
Teamwork in the eye of the beholder:
ICU RNs and ICU MDs rate each other

62 Michigan ICUs 2004
Only ICUs with 5 or more physicians reported here (all had 5 or more RNs)
Teamwork Climate Across Michigan ICUs

The strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care.

No BSI = 5 months or more with zero
Only one verification injury in a hospital where RN perceptions of safety were more than 60%
Perceptions of Hospital Safety Climate and Incidence of Readmission

Luke O. Hansen, Mark V. Williams, and Sara J. Singer

Objective. To define the relationship between hospital patient safety climate (a measure of hospitals’ organizational culture as related to patient safety) and hospitals’ rates of rehospitalization within 30 days of discharge.


Data Collection. Robust multiple regressions used 30-day risk-standardized readmission rates as dependent variables in separate disease-specific models (acute myocardial infarction [AMI], heart failure [HF], pneumonia), and measures of safety climate as independent variables. We estimated separate models for all hospital staff as well as physicians, nurses, hospital senior managers, and frontline staff.

Principal Findings. There was a significant positive association between lower safety climate and higher readmission rates for AMI and HF \( (p < .05 \) for both models). Frontline staff perceptions of safety climate were associated with readmission rates \( (p < .01) \), but senior management perceptions were not. Physician and nurse perceptions related to AMI and HF readmissions, respectively.

Conclusions. Our findings indicate that hospital patient safety climate is associated with readmission outcomes for AMI and HF and those associations were management level and discipline specific.
What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?

A Qualitative Study

Leslie A. Curry, PhD; Erica Spatz, MD; Emily Cherlin, PhD, MSW; Jennifer W. Thompson, MPP; David Berg, PhD; Henry H. Ting, MD, MBA; Carole Decker, RN, PhD; Harlan M. Krumholz, MD, SM; and Elizabeth H. Bradley, PhD

Background: Mortality rates for patients with acute myocardial infarction (AMI) vary substantially across hospitals, even when adjusted for patient severity; however, little is known about hospital factors that may influence this variation.

Objective: To identify factors that may be related to better performance in AMI care, as measured by risk-standardized mortality rates.

Design: Qualitative study that used site visits and in-depth interviews.

Setting: Eleven U.S. hospitals that ranked in either the top or the bottom 5% in risk-standardized mortality rates for 2 recent years of data from the Centers for Medicare & Medicaid Services (2005 to 2006 and 2006 to 2007), with diversity among hospitals in key characteristics.

Participants: 158 members of hospital staff, all of whom were involved with AMI care at the 11 hospitals.

Measurements: Site visits and in-depth interviews conducted with hospital staff during 2009. A multidisciplinary team performed analyses by using the constant comparative method.

Results: Hospitals in the high-performing and low-performing groups differed substantially in the domains of organizational values and goals, senior management involvement, broad staff presence and expertise in AMI care, communication and coordination among groups, and problem solving and learning. Participants described diverse protocols or processes for AMI care (such as rapid response teams, clinical guidelines, use of hospitalists, and medication reconciliation); however, these did not systematically differentiate high-performing from low-performing hospitals.

Limitation: The qualitative design informed the generation of hypotheses, and statistical associations could not be assessed.

Conclusion: High-performing hospitals were characterized by an organizational culture that supported efforts to improve AMI care across the hospital. Evidence-based protocols and processes, although important, may not be sufficient for achieving high hospital performance in care for patients with AMI.

Primary Funding Source: Agency for Healthcare Research and Quality, United Health Foundation, and the Commonwealth Fund.

Ann Intern Med. 2011;154:384-390. For author affiliations, see end of text.
Nurse input is well received in this work setting.

Note: Use the multicolored bars to see how you fit with the benchmark archive. If you have less red and more green than the benchmark, you are more positive than the benchmark. If the colors all match up, you are about the same as the benchmark.
Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient).
The culture in this clinical area makes it easy to learn from the errors of others.
Debriefing culture data locally

Local debrief sessions target improvement at the clinical area level

Sessions empower caregivers to “own the data”

Use the DEBRIEFer tool
Workforce Engagement - 7S Surgical Floor

- Our organization has a bright future
- Leadership communicates the vision in a way that motivates me
- We have open and honest two-way communication
- We maintain focus on the Mission and Core values while embracing change
- I would recommend our organization to others who need care
- I feel appreciated for my work
- My input is valued
- Leadership responds appropriately to feedback from front line caregivers
- I am encouraged to learn and grow professionally
- I am supported in dealing with difficult situations at work

2009 Percent Favorable
2010 Percent Favorable
2010 Hospital Partner
How Healthy Is Our Culture?
Safety Attitudes Questionnaire Domain Scores

Goal Zone
Danger Zone

Average Percent Positive

Teamwork Climate, Safety Climate, Job Satisfaction, Stress Recognition, Working Conditions, Perceptions Of Facility Management, Perceptions Of Local Management

2009 2011
How Healthy Is Our Culture?

Safety Attitudes Questionnaire Domain Scores

Attribution: Margaret Cornell, MS, RN
Linking Culture and Outcomes: RI ICU Effort to Decrease Infection

ICU’s that reflected on their SAQ scores and took action:

- Increased their SAQ scores in 5 of 6 domains
- Achieved a 10.2% decrease in BSI rates
- Achieved a 15.2% decrease in VAP rates

ICU’s that did NOT reflect on their SAQ scores:

- Increased their SAQ scores in 1 of 6 domains
- Achieved a 2.2% decrease in BSI rates
- Achieved a 4.8% increase in VAP rates

Attribution: Margaret Cornell, MS, RN
Building a Learning System
Allan Frankel, MD
Michael Leonard, MD
Why hospitals don't learn from failures:

Organizational and psychological dynamics that inhibit system change

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November 6, 2002
Failures of Organizational Learning

Macro - preference for current competencies and routines inhibits the recognition for the need to change.

Micro - interpersonal defensiveness reduces “inquiry” - reduces leaders ability to detect and manage error. This lack of valid data inhibits learning and suboptimal decisions

The Middle - missing or poor learning systems, exacerbated by a lack of psychological safety, limits improvement, strategic redirection and innovation

Attribution: Amy Edmondson, HBS
Acute Medicines Unit Workstream
Ninewells Hospital, Dundee, Scotland
Arun Chaudhur, Medical Director
Arun Chaudhur, Medical Director
ICU Percent of Patients Receiving all Four Aspects Of Ventilator Bundle

Annotations:
1: Marked beds at 30 degree angle
2: Fact Sheet for staff education
3: Poster with weekly data feedback
4: Vent bundle posted in all vent patient rooms
5: Began initial trials of Daily goal sheet and pre-extubation sheet
6: Initiated Powerpoint education for RT/RN
7: Initiated Clinical Pharm rounds
8: 1st test of multidisciplinary rounds
9: Expanded use of Pre-extubation sheet
10: Staff education on Goal sheet; mini inservices on unit on SBT and Pre-extubation sheet
11: Incorporated Goal Sheet into Multidisciplinary Rounds
12: Impact Extravaganza (staff/MD education)
13: Expanded multidisciplinary rounds to include additional disciplines
14: Check compliance on night shift past 2 weeks
15: New sign at HOB,
16: One on one follow up by Nursing & RT managers on collaboration in weaning process
“What is the variation in one system over time?”
Walter A. Shewhart - early 1920’s, Bell Laboratories

Every process displays variation:

- Controlled variation stable, consistent pattern of variation “chance”, constant causes
- Special cause variation “assignable” pattern changes over time
Mercy Regional Medical Center

© Mercy 2010 ‘Turtle Board’
North Shore Medical Center, Partners Healthcare, Salem Massachusetts, ER Transformational Team
North Shore Medical Center, Partners Healthcare, Salem Massachusetts, ER Transformational Team
Learning System

The Cyclic Flow of Information

Social Metrics – Attitudes / Perceptions
Clinical Metrics – Process / Outcome / Risk
Operational Metrics

Feedback
Validation
Improvement

Data Acquisition
Analysis / Integration
Debriefing with Action

Leadership
Engagement / Support to Unit
Level Caregivers

Tracking / Measuring
Engaging the Voice of the Patient
Patient Centered Care

What does patient-centered care look like?
How do you design your care processes?
What about health literacy?
How will you incorporate their voice?
How will you tell your community how good you are?
How will you talk to patients when something goes wrong?
Health Literacy – The Silent Epidemic

21% of the American Public cannot read the headlines of a newspaper.

48% cannot decipher messages with words and numbers, i.e. instructions about a bus route, a pie chart or a bar graph.
“Teach Back”

Ask a patient to describe or repeat back in his or her own words what has just been told or taught - “You’ve heard us talk about this, please take a minute and tell how you are going to explain this to your family.”

When the health professional hears gaps in the patient’s understanding, further teaching can be accomplished to correct misunderstandings.

Never ask whether patients understand; they always say “yes.”
% Patients Weighing Correctly: Use of “Teach Back” at First Call Post Discharge

At the 1'st Call Back

- Yes: 51%
- No: 49%

At the 1 Week Call Back

- Yes: 78%
- No: 22%

Iowa Health System:
Health Literacy post discharge intervention with CHF patients.
Failure to weigh daily determined to be a primary contributor to readmission.
Patients are called at 48 hours and 1 week post discharge.
Teach Back is used to clarify their understanding.

Courtesy Gail Nielsen
How Bad Is Your Congestive Heart Failure?
You can tell how well your heart is doing by how you feel and what you can do.

**SWELLING**
- **Good** – No Swelling
- **OK** – Swelling in Ankle or Shin
- **Bad** – Swelling in Knee Area

Call the UNC Clinic / 919-843-6480

**WALKING**
- **Good** – You can walk easily with no shortness of breath
- **OK** – Shortness of breath when walking fast
- **Bad** – Short of breath at rest

Call the UNC Clinic / 919-843-6480

**SLEEPING**
- **Good** – Sleeping flat, no shortness of breath
- **OK** – Needing 2 pillows or more to avoid shortness of breath
- **Bad** – Have to sleep upright to avoid shortness of breath

Call the UNC Clinic / 919-843-6480

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http://www.hsl.unc.edu/Services/Guides/focusonhealthlit.cfm
Effective Teamwork and Communication
Practical tools and behaviors to enhance teamwork and deliver high quality, safe care.
Effective Communication and Teamwork Requires:

<table>
<thead>
<tr>
<th>Structured Communication</th>
<th>Briefing/ Checklist, SBAR, Debrief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertion/Critical Language</td>
<td>Key words, the ability to speak up and stop the show - “Clarity”</td>
</tr>
<tr>
<td>Psychological Safety</td>
<td>An environment of respect</td>
</tr>
<tr>
<td>Effective Leadership</td>
<td>Flat hierarchy, sharing the plan, continuously inviting other team members into the conversation, explicitly asking people to share questions or concerns, using people’s names</td>
</tr>
</tbody>
</table>
Why Communication?

The overwhelming majority of untoward events involve communication failure.

Usually somebody knows there’s a problem but can’t get everyone in the same movie.

The clinical environment has evolved beyond the limitations of individual human performance.
Effective Communication

- Have a plan
- The value of a structured process
- Hand-offs are dangerous
- Structured language/clarity
- Who owns the patient?
- What are the parameters for increasing the intensity of care?
Effect of a Comprehensive Surgical Safety System on Patient Outcomes

Eefje N. de Vries, M.D., Ph.D., Hubert A. Prins, M.D., Ph.D.,
Rogier M.P.H. Crolla, M.D., Adriaan J. den Outer, M.D.,*
George van Andel, M.D., Ph.D., Sven H. van Helden, M.D., Ph.D.,
Wolfgang S. Schlack, M.D., Ph.D., M. Agnès van Putten, B.Sc.,
Dirk J. Gouma, M.D., Ph.D., Marcel G.W. Dijkgraaf, Ph.D.,
Susanne M. Smorenburg, M.D., Ph.D., and Marja A. Boermeester, M.D., Ph.D.,
for the SURPASS Collaborative Group†

ABSTRACT

BACKGROUND
Adverse events in patients who have undergone surgery constitute a large proportion of iatrogenic illnesses. Most surgical safety interventions have focused on the operating room. Since more than half of all surgical errors occur outside the operating room, it is likely that a more substantial improvement in outcomes can be achieved by targeting the entire surgical pathway.

METHODS
We examined the effects on patient outcomes of a comprehensive, multidisciplinary surgical safety checklist, including items such as medication, marking of the operative site, and use of postoperative instructions. The checklist was implemented in six hospitals with high standards of care. All complications occurring during admission were documented prospectively. We compared the rate of complications during a baseline period of 3 months with the rate during a 3-month period after implementation of the checklist, while accounting for potential confounders. Similar data were collected from a control group of five hospitals.

RESULTS
In a comparison of 3760 patients observed before implementation of the checklist with 3820 patients observed after implementation, the total number of complications per 100 patients decreased from 27.3 (95% confidence interval [CI], 25.9 to 28.7) to 16.7 (95% CI, 15.6 to 17.9), for an absolute risk reduction of 10.6 (95% CI, 8.7 to 12.4). The proportion of patients with one or more complications decreased from 15.4% to 10.6% (P<0.001). In-hospital mortality decreased from 1.5% (95% CI, 1.2 to 2.0) to 0.8% (95% CI, 0.6 to 1.1), for an absolute risk reduction of 0.7 percentage points (95% CI, 0.2 to 1.2). Outcomes did not change in the control hospitals.
Briefings

- Share the game plan
- Set the stage – psychological safety
- Norms of conduct
- Disavow perfection - a little humility goes a long way
- Engage every participant using eye contact and people’s names
- Explicitly ask for input about concerns or issues
- Provide information and talk about next steps
- Seek useful information
- Update as needed – build into procedure
Setting the Stage

Set the stage actively and positively, think out loud, invite the team into the conversation both for their suggestions and concerns, use their names, specifically ask them to speak

“I don’t have any pride invested here. I just want to get this right, so if you think of anything helpful or see me doing anything wrong, please let me know.”
SBAR

Situation
Background
Assessment
Recommendation
A Systematic Approach to Excellence

**Engaged Leaders** - build skill and confidence in leading safety for your organization

**Culture** - focus on a couple areas of our culture where we have significant opportunity to make it better for us and the patients

**Effective Teamwork** - embed behaviors in a way that is actionable and measurable, and becomes the way we work

**Reliable Processes** - processes that can be measured and continually improved through iterative learning

**Continual Learning** - systematically capture relevant data in way that drives continuous improvement and increases trust

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