Spreading Bundle Tools and Resources on High Reliability Culture Event

December 7, 2023

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Welcome!

Jenny Twesten, MPH
Managing Director, Health Research
Bizzell US
Data Validation & Administrative Contractor (DVA)
Moderator

Reminders

- Today's event will be divided into a morning session and afternoon session with a 45-minute lunch break. We hope you are able to listen to all of the presentations and will come away with renewed enthusiasm and some additional high reliability tools and resources to help reach the goal of providing safer, superior quality care.
- Please be sure to participate as we go along and submit your questions and comments via the Q&A feature.
- The slides, recording and resources from today's event will be posted on QIOProgram.org within a week.

Agenda – Morning Session

Time (EST)	Topic	Presenter
10:00 – 10:15	CMS Leadership Welcome	Anita Monteiro, iQIIG Director Ally McCoy, DQIIMT Director
10:15 – 10:45	Resiliency Engineering and Human Factors as a Path to High Reliability Organizing	Oren Guttman, MD, MBA Healthcare Association of New York State (HANYS)
10:45 – 11:15	Experiences Implementing High Reliability Organizing in Hospitals	Russell Kohl, MD, FAAFP TMF Health Quality Institute
11:15 – 11:45	Implementing an Incident Decision Tree	Jen Murphy, MHA, CCPS Health Quality Innovators
11:45 – 12:30	Lunch Break	

Agenda – Afternoon Session

Time (EST)	Topic	Presenter
12:30 – 1:00	Iowa Healthcare Collaborative (IHC) - High Reliability Organization Wins and Applying High Reliability Organization Concepts in Critical Access Hospitals	Tom Evans, MD, FAAFP Julia Pyle, MSN, RN / Julie Noah, MBA, MSN, RN / Jennifer Newton, MSN, RN Iowa Healthcare Collaborative (IHC)
1:00 – 1:30	A Critical Access Hospital's Journey to High Reliability	Carrie Coen Jeannie Eylar Alliant Health Solutions
1:30 – 2:00	Addressing Characteristics of a High Reliability Organization	Rebecca Boll, MSPH, CPHQ / Julia Harbuck-Valley, RN, BSN / Jennifer Anderson, CPHQ / Jim McCarville Island Peer Review organization (IPRO)
2:00 – 2:15	Break	

Agenda – Afternoon Session Continued

Time (EST)	Topic	Presenter
2:15 – 2:45	Learning from Community Organizing Approaches to Build High Reliability Organizations	Risa Hayes, CPC Telligen
2:45 – 3:15	Leveraging the Zero Harm Program to Promote High Reliability	Beth Morgan, MHA, BSN, RN, CNOR, CPHQ Nan Carter, MPH Health Services Advisory Group (HSAG)
3:15 – 3:30	Break	
3:30 – 4:00	HRO is a Journey, NOT a Destination: Lessons From an International Roundtable on Healthcare Resilience During the Pandemic	Bruce Spurlock, MD Convergence Health Consulting
4:00 – 4:30	Q&A/Open Discussion and Event Wrap Up	CMS

Welcome from CMS Leadership

Anita Monteiro
Director
Quality Improvement & Innovation Group (iQIIG)
Centers for Medicare & Medicaid Services

Ally McCoy MSN, RN
Division Director
Center for Clinical Standards & Quality (CCSQ)
Division of Quality Improvement & Innovation Models Testing (DQIIMT)
Centers for Medicare & Medicaid Services

Resiliency Engineering and Human Factors as a Path to High Reliability Organizing

Healthcare Association of New York State (HANYS)

December 7, 2023

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iQUALITY IMPROVEMENT & INNOVATION GROUP

Meet Your Speaker

Oren Guttman, MD, MBA

Ed Asplundh Chief Quality and Patient Safety Officer

Jefferson Health Abington

Enterprise Vice President for High Reliability and Patient Safety

Jefferson Health

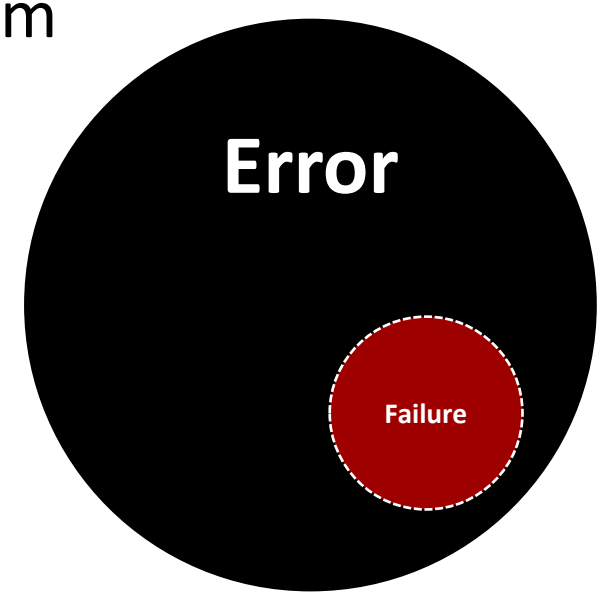
High Reliability Has Two Key Strategies

Reliability in Healthcare

- **Reliability** = when a system or value stream gets the Intended Performance (process) & Expected Result (outcome) throughout the expected time.
- Optimizing Systems system safety means to increase the reliability of the system

Resiliency in Healthcare

- The ability to recover, “bounce back” and sustain required operations under both expected and unexpected conditions.
- Property of the *relationships among components* than in the components themselves.
- Something a System *does* rather than something a system *has*.
- Very much a result of human expertise, not experience, in recognizing error, rescuing error from turning into failure, and containing effects of failure

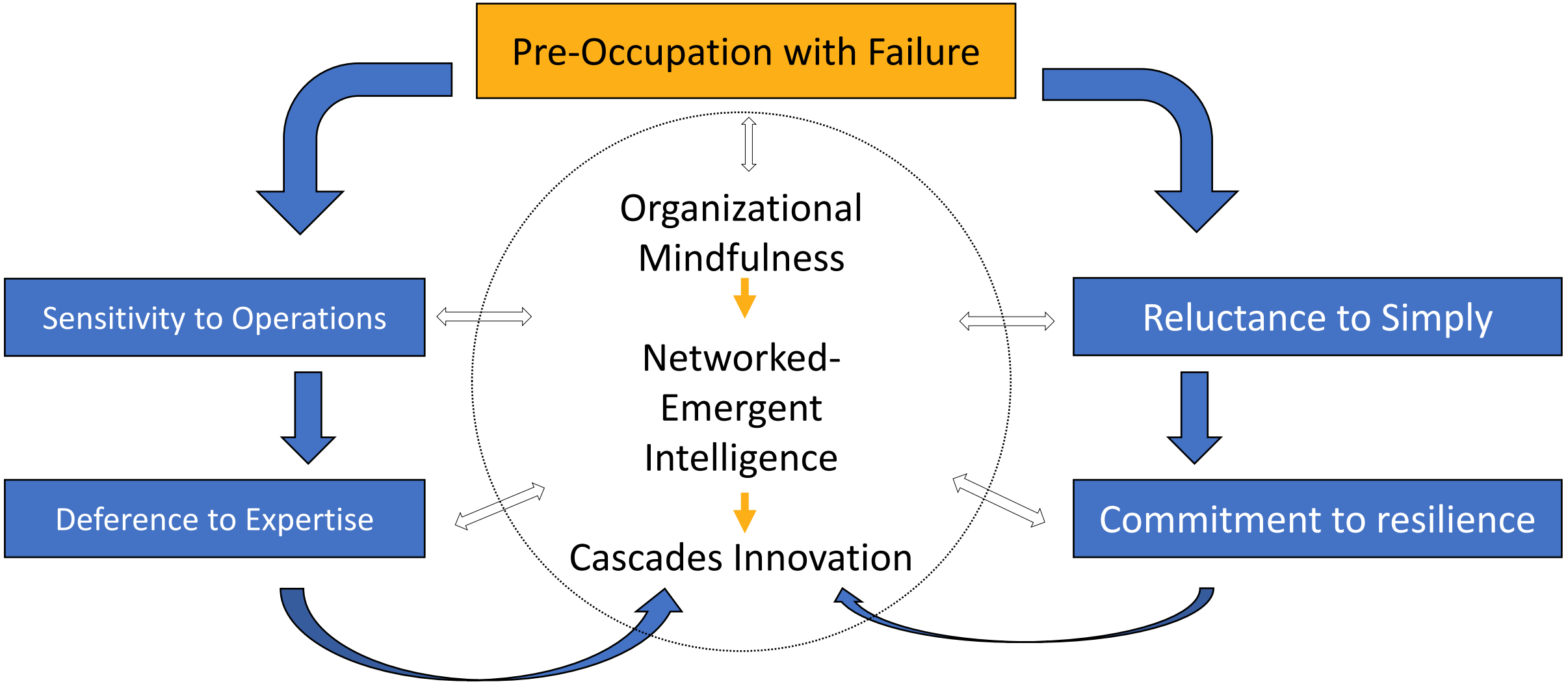


Resilience Engineering: New directions for measuring and maintaining safety in complex systems Final Report December 2008 Sidney Dekker, Erik Hollnagel, David Woods and Richard Cook

HRO: It's a Journey, Not a Destination

- High Reliability is not a Destination, its an ongoing journey.
- It's Not a *Noun* (Organization), but rather a *Verb* (Organizing)
  - Situational Awareness…focus on mindfulness
  - Avoidance of complacency…continuously need to organize…
  - Need to adapt, improvise, and be agile.
  - Connective intelligence…property of the system, not of its parts

High Reliability Organizing has 5 Guiding Principles



Key Message #1

Healthcare is on fire and change is here to stay

Staffing and Human Teams are Unstable

Turnover tsunami

Nearly 1 in 5 Health Care Workers Have Quit Their Jobs During the Pandemic

Medical workers cited COVID-19, poor pay and burnout as reasons for layoffs, resignations

Modern Healthcare

NEWS INSIGHTS TRANSFORMATION DATA/LISTS OP-ED AWARDS EVENTS LISTEN

October 06, 2021 04:40 PM

Hospitals spending $24B more per year on clinical labor

MARI DEVEREAUX

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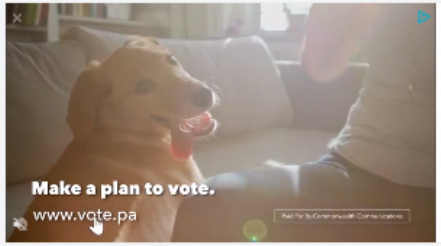
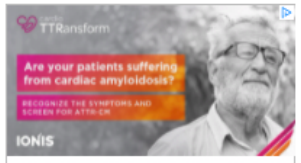


Learn More

U.S.

More Than Half a Million Health Care Workers Quit Their Jobs in August

BY KHALEDA RAHMAN ON 10/13/21 AT 6:57 AM EDT

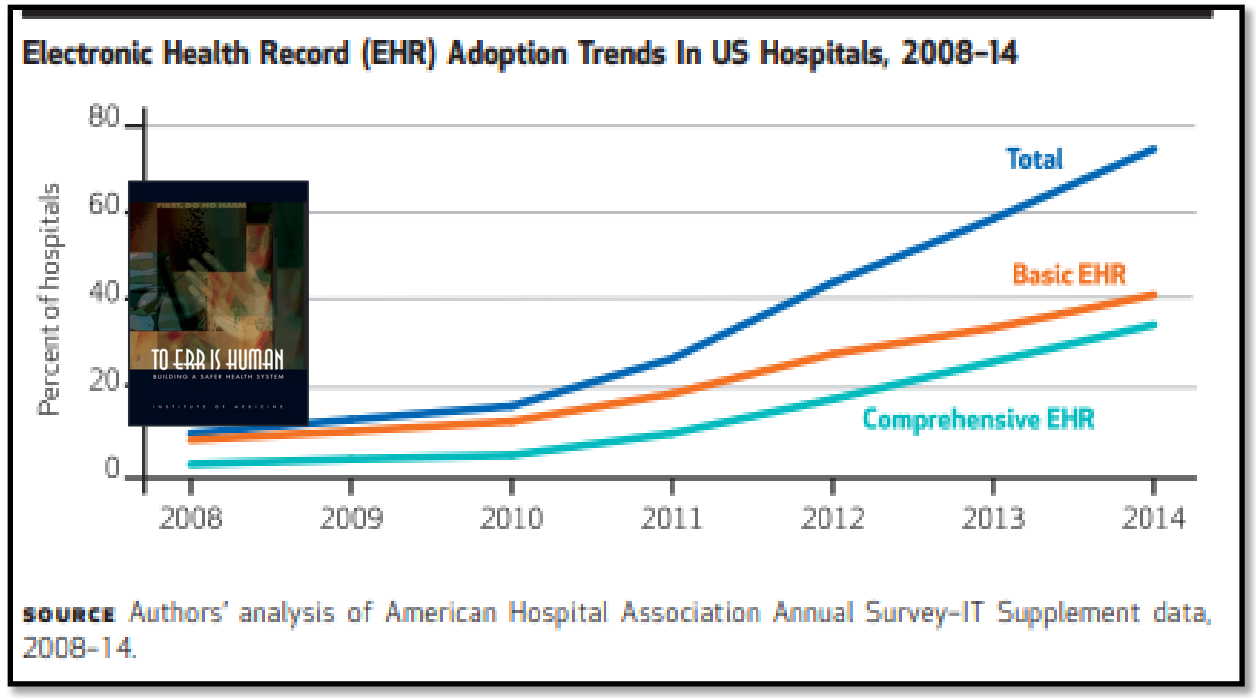


NEWS

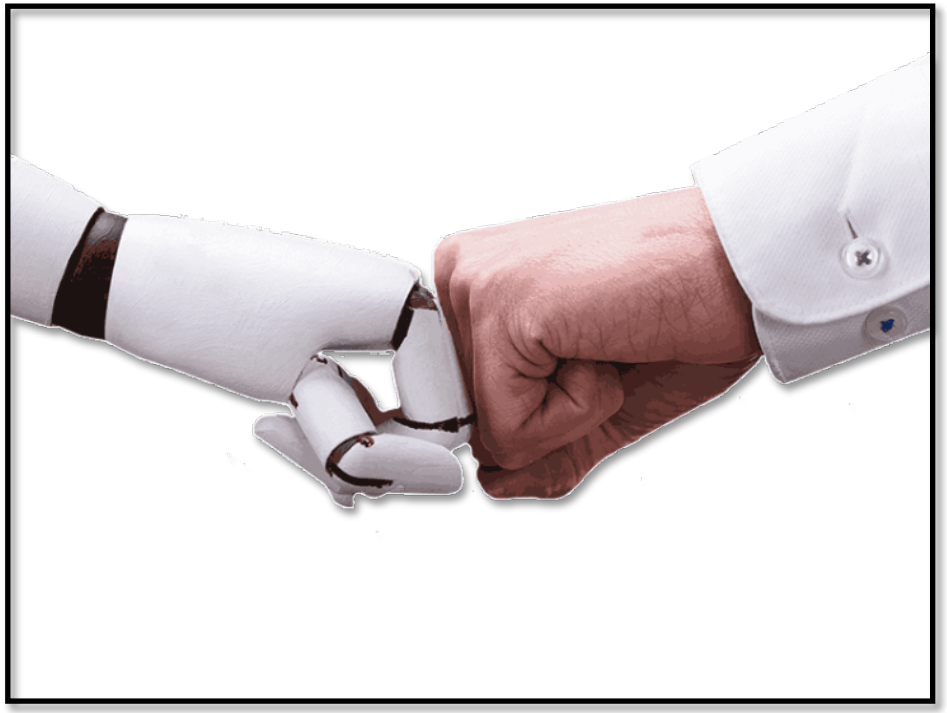
A record 4.3 million workers walked off the job in August

The number of people quitting their jobs is still smashing records.

Human-Machine Teaming is Our New Reality



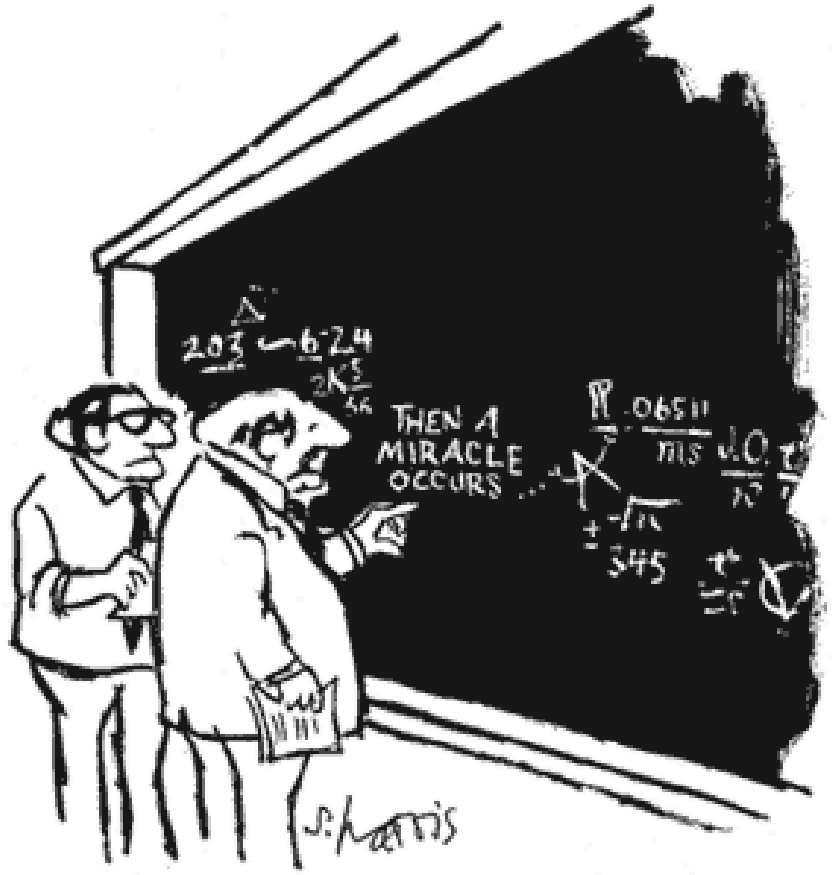
The machines are no longer our tools, they are our partners



Key Message #2

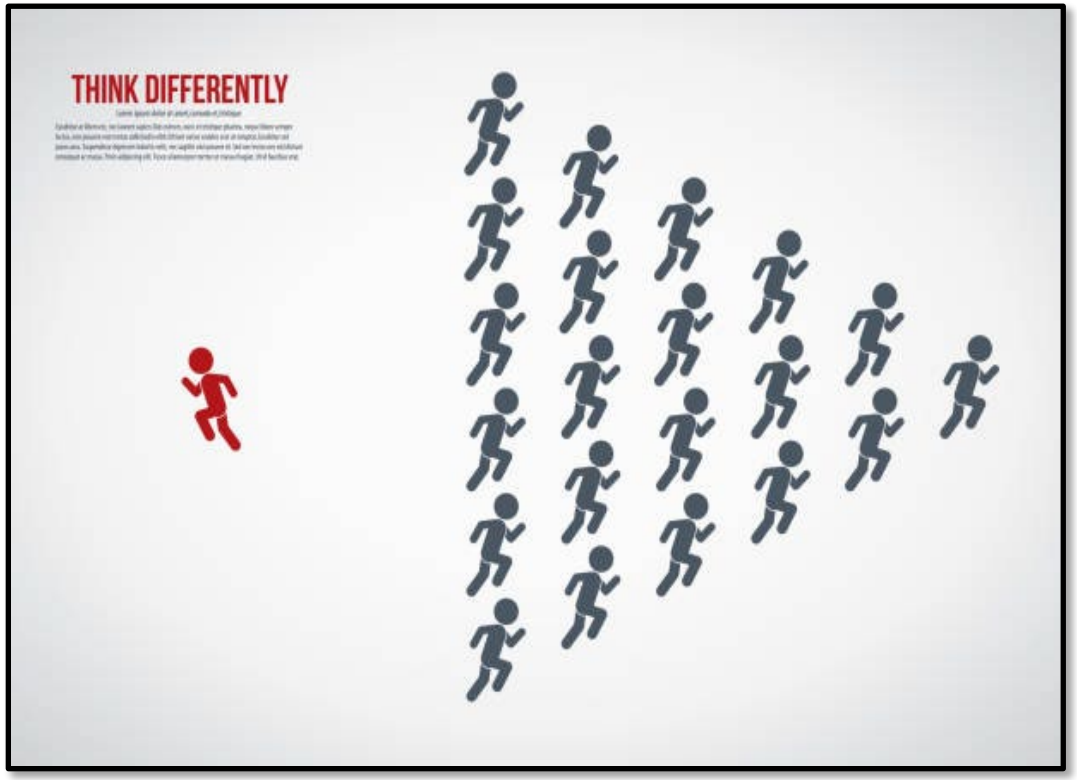
What Got Us Here,
Won't Get Us There…

Quote by Marshal Goldsmith



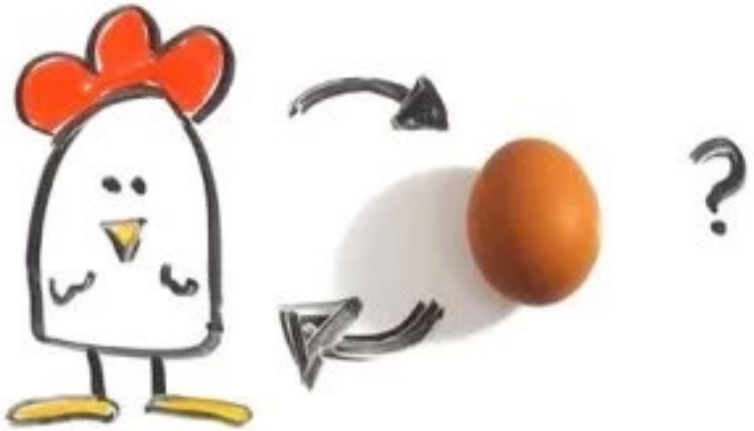
"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

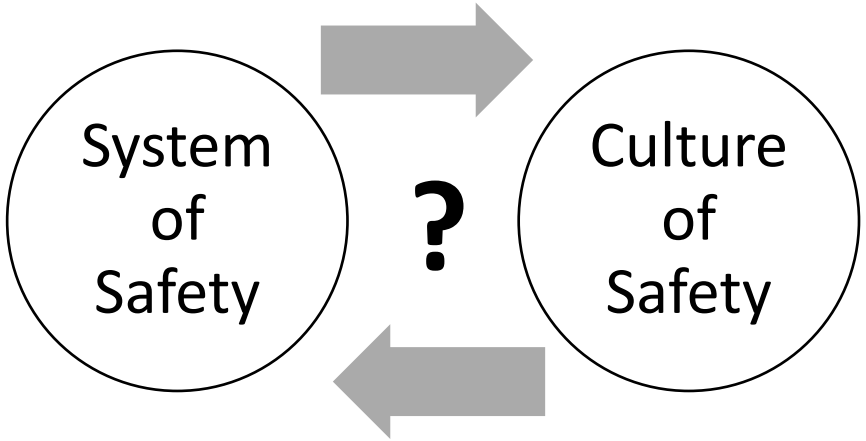
We Need Courage to Challenge Sacred Assumptions About How to Get to Safe



Maybe THE Question to Move Us Along…

Chicken or the egg—where do you start?





Does a Culture of Safety define the operating system or does a System of Safety define the culture?

We need BOTH!!!

Focusing on Culture Before/Without Systems Redesign Burns Out Clinicians

A significant contributor to staff burnout is poor system design

- Clinicians hold themselves to high professional standards.
- We don’t hold our tools and technology to those same standards.
- Then we ask staff to care for patients in environments with tools that are not designed well for the people that use them… and then expect them to be superhuman and not make operator errors.
- Focusing on behavioral change before system and process optimization leads to staff burnout and frustration.

Focusing on Safety Culture Without a Focus on System Redesign is Distracting at Best, Ineffective at Worst

Focus on safety culture can be distracting

"There is a risk that a focus on cultural dimensions of safety (which, in fact, are often interpreted by managers within industry as the behavioral dimensions of safety), less attention is paid to more effective levers for safety improvement, such as design work on inherent safety and the implementation of technological improvements." [Rollenhagen 2010]

ELSEVIER

Safety Science

Volume 48, Issue 2, February 2010, Pages 268-278

Can focus on safety culture become an excuse for not rethinking design of technology?

Carl Rollenhagen

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https://doi.org/10.1016/j.ssci.2009.07.008 Get rights and content

Abstract

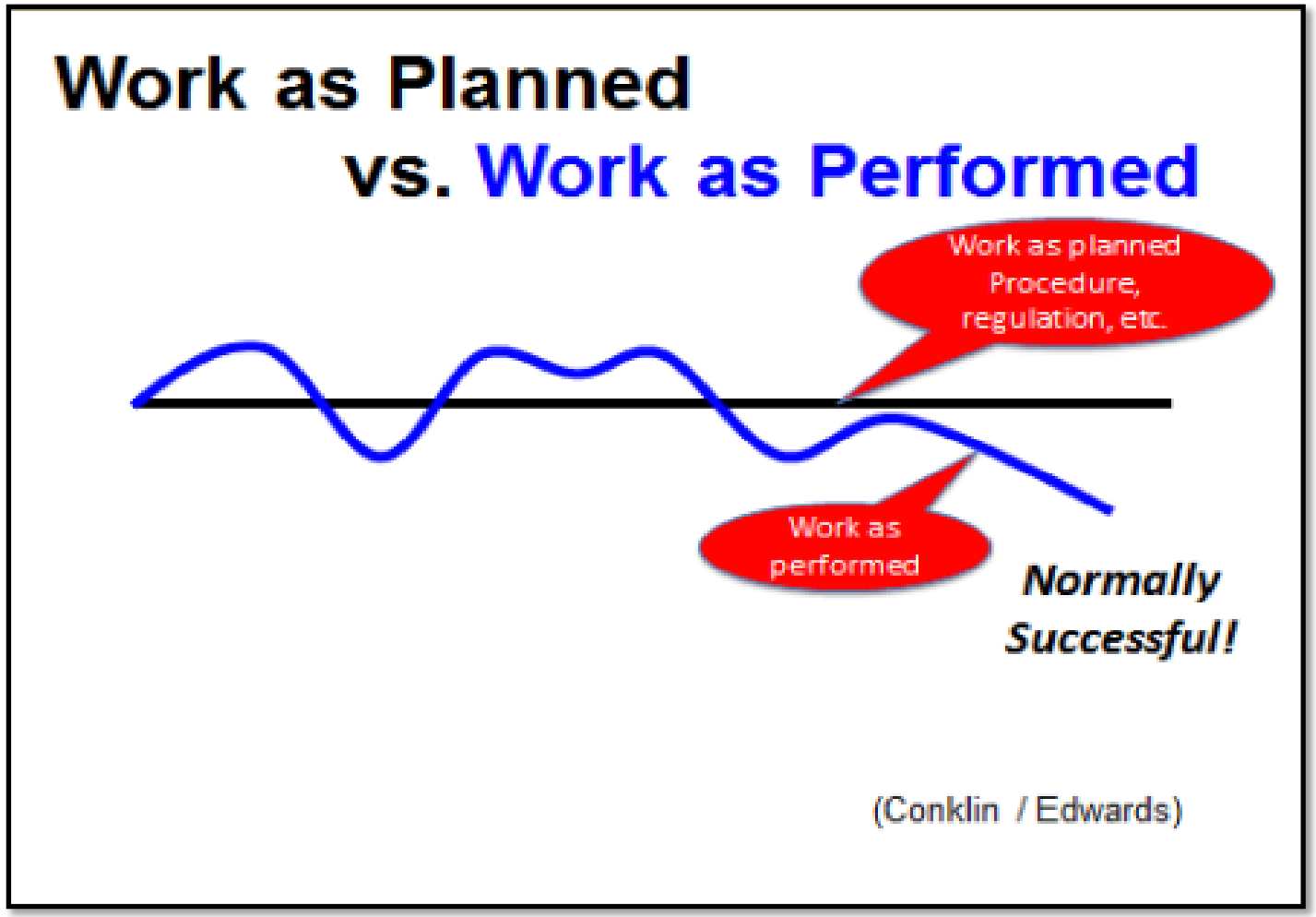
Two generic organisational contexts associated with technological designs in relation to safety culture are discussed: (1) operating organisations using existing technologies, and (2) design organisations as producers of technologies. It is argued that the concept of safety culture, if misused, may lead to the adoption of non-effective change strategies in the operational context. On the other hand, it is also argued that design organisations should invest more attention to issues commonly subsumed under the concept of safety culture. In this case, however, the concept of safety culture has to be adapted to fit the demands facing design organisations. Issues of morality and their association with the safety culture concept will be discussed. It is suggested that a stronger focus on understanding innovation and safety together should nourish future research about culture's influence on design and safety.

Socio-Technical Systems in HC are Complex

Socio-Technical System

- Pieces of the system interacting in ways unanticipated
- Dependency of different parts of the system on each other
- Changing contexts, rules
- Coupling: one part of the system can't act without another, inter-dependence
- Resonance: risks are additive in a non-linear way
- Emergence: risks appear with scarcity.
- Drip: safeguards themselves can be risks
- Human Limitations in Capability and Capacity to do work
- Human's naturally drift or make micro-adjustments to account for failing systems. (Safety 2, Anti-fragility)

Work as We Imagine/Plan for it Does NOT = Work as Performed



Key Message #3

Respond to system complexity with more resiliency, not just, and maybe even more, than reliability.

Make it easy to detect errors and rescue from error becoming failure.

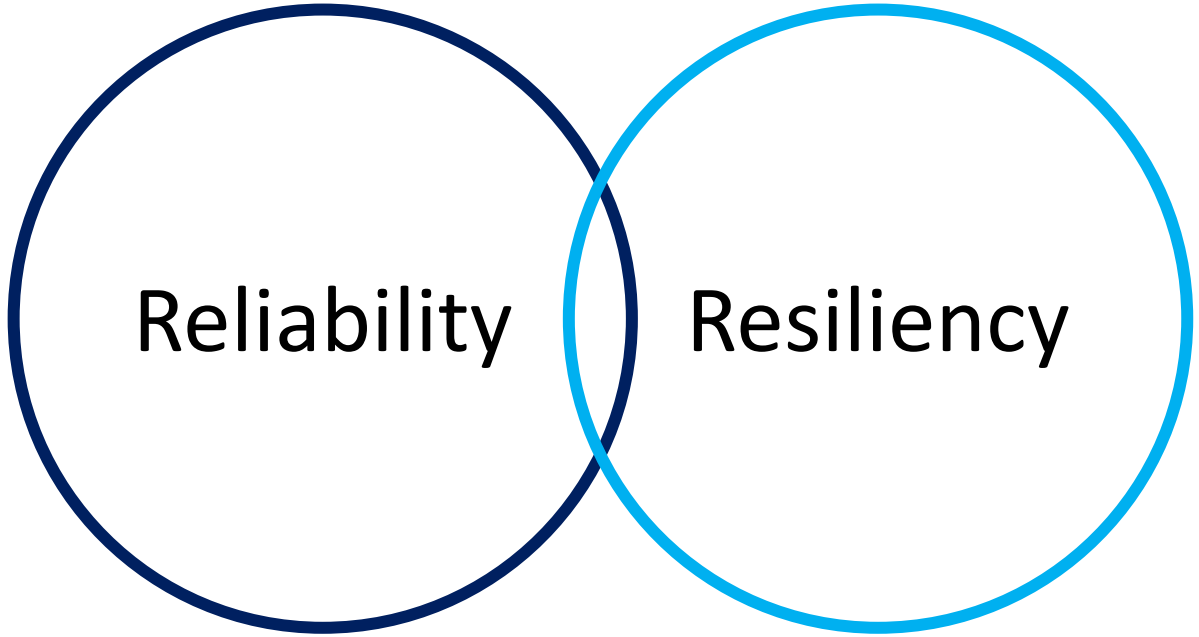
Resiliency, Not Just Reliability

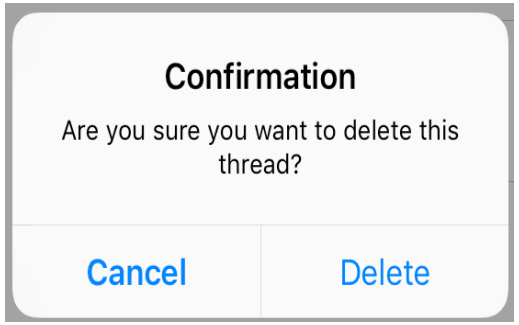
"In complex environments (i.e. where WAD is not WAI), resilience often spells success, while even the most brilliantly engineered fixed solutions are often insufficient or counterproductive."

- Gen Stanley McChrystal *Team of Teams* 2015

Framework for the Work

- Get it right the first time
- Avoid errors
- Optimizing a system to produce the intended results without failure more often than not
- Days without failure





- Assumes you will NOT always get it right the first time
- Expects errors
- Anticipates errors will occur eventually
- Number of precursor errors Recognized
- Days with rescue

Making Rescue Easy is the Key to Safer Outcomes

Resiliency

- Same complication rates
- Different surgical outcomes
- Attributed to ability to *rescue* patients from complications

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Variation in Hospital Mortality Associated with Inpatient Surgery

Amir A. Ghaferi, M.D., John D. Birkmeyer, M.D., and Justin B. Dimick, M.D., M.P.H.

From the Michigan Surgical Collaborative for Outcomes Research and Evaluation, the Department of Surgery, University of Michigan, Ann Arbor. Address reprint requests to Dr. Ghaferi at Michigan Surgical Collaborative for Outcomes Research and Evaluation, 211 N. Fourth Ave., Suite 201, Ann Arbor, MI 48104, or at aghaferi@umich.edu.

N Engl J Med 2009;361:1368-75.

ABSTRACT

BACKGROUND

Hospital mortality that is associated with inpatient surgery varies widely. Reducing rates of postoperative complications, the current focus of payers and regulators, may be one approach to reducing mortality. However, effective management of complications once they have occurred may be equally important.

METHODS

We studied 84,730 patients who had undergone inpatient general and vascular surgery from 2005 through 2007, using data from the American College of Surgeons National Surgical Quality Improvement Program. We first ranked hospitals according to their risk-adjusted overall rate of death and divided them into five groups. For hospitals in each overall mortality quintile, we then assessed the incidence of overall and major complications and the rate of death among patients with major complications.

RESULTS

Rates of death varied widely across hospital quintiles, from 3.5% in very-low-mortality hospitals to 6.9% in very-high-mortality hospitals. Hospitals with either very high mortality or very low mortality had similar rates of overall complications (24.6% and 26.9%, respectively) and of major complications (18.2% and 16.2%, respectively). Rates of individual complications did not vary significantly across hospital mortality quintiles. In contrast, mortality in patients with major complications was almost twice as high in hospitals with very high overall mortality as in those with very low overall mortality (21.4% vs. 12.5%, P<0.001). Differences in rates of death among patients with major complications were also the primary determinant of variation in overall mortality with individual operations.

CONCLUSIONS

In addition to efforts aimed at avoiding complications in the first place, reducing mortality associated with inpatient surgery will require greater attention to the timely recognition and management of complications once they occur.

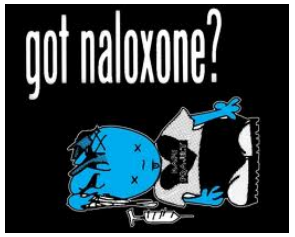
Resiliency Engineering and 4Rs

Recognizing

Error, hazardous condition

Rescue

Failure



Restrict

Spread

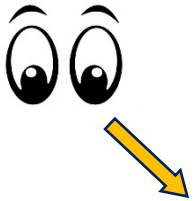
Reverse

Catastrophic failure

Early Recognition and Rescue is the key to advancing safety in complex systems

Use Case - CLABSI

Recognizing



Error, hazardous condition → Rescue → Failure → Restrict → Spread → Reverse → Catastrophic failure

ERROR
- Femoral line
- Line placed dirty
- No CHG bath
- No dressing Change

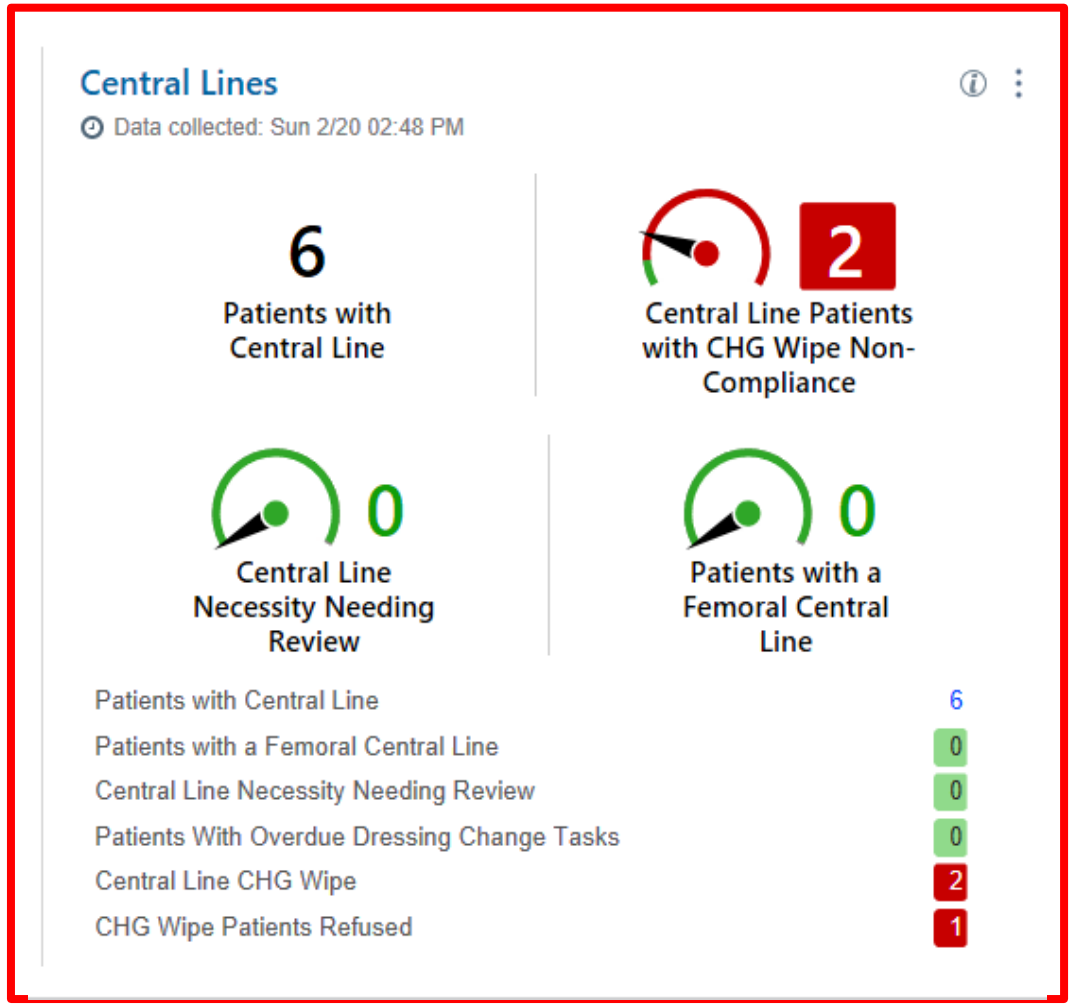
CLABSI

Line SEPSIS

Death

Leverage EMR to Increase Detectability of Errors That Could Lead to Failure

- AM rounds—RNs with team
- Daily shift Change Safety Sweep 2x/day—
  - Rescue in PM safety sweep
- Weekly staff meetings—RN manager
- Clinical education team deployed as a “clinical risk management team” to support frontline staff who are overwhelmed.
- Divisional and local safety huddles



Huddle Q&S Dashboard Utilization

14,000 runs/month

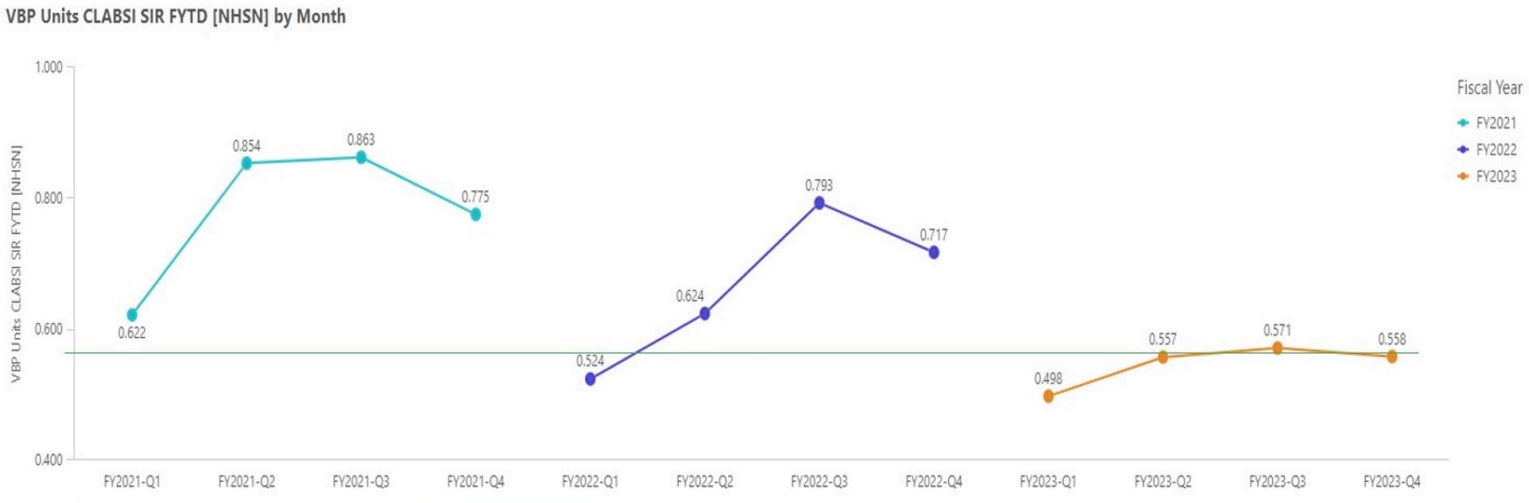
125 Nursing units

112 runs/month on a unit

3.73 runs/day on a unit

3 years

CLABSI: Sustained Improvement



(reference: Zimlichman Et al. JAMA Internal Medicine December 9/23, 2013 Volume 173, Number 22, 2039-2046)

Jan. 2020 to Dec. 2022 (through COVID)

- SIR went from 0.845 to 0.63
- 25% reduction (VBP units)
- Avoided 65 infections (O: 155, P or E: 220)
- Cost per infection: $45,814
- Total Cost Avoidance Savings: 65 * $45,814 = $2,977,910

Key Message #4

"Every system is perfectly designed to get the results it gets."

- Quote by Paul Batalden, Patient Safety & Quality Healthcare blog on August 3, 2015,

Stop asking the humans to do more, try harder, remember more, be more vigilant…

Instead, utilize human adaptation as a source of strength and identify broken systems and redesign.

Great Catch, Great Save & Mission Moment Program Expansion

Great Catch

=

System Fix

Great Catch: Identifying a failure BEFORE it reaches the patient and results in a ***system or process fix, affecting many patients going forward***.

Great Save

=

Rescue

Great Save: Taking extraordinary action to *rescue* a single patient from deterioration and/or harm

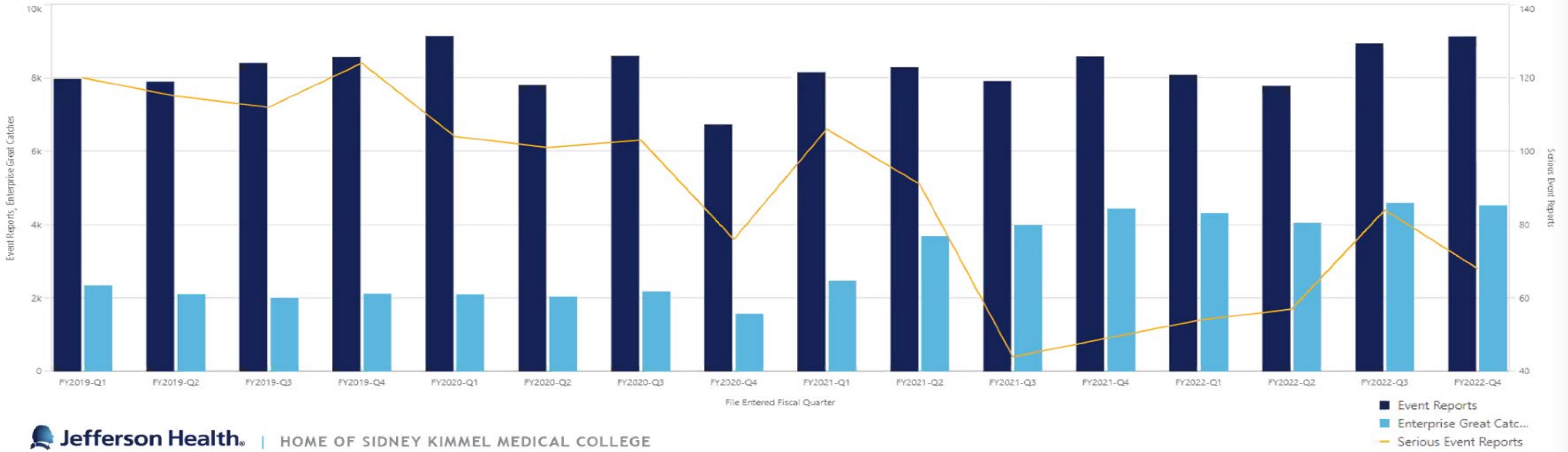
Mission Moment

=

Service Excellence

Mission Moment: Exceptional demonstration of *service excellence (i.e. compassion, caring, etc.).*

GC Done Differently—A Proactive Focus on System Safety



Jefferson Health | HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

1500

Monthly average of Great Catches reported

~3000

Monthly average of safety events reported

⬇ 16%

Average annual decrease in Serious Reported Events since FY20

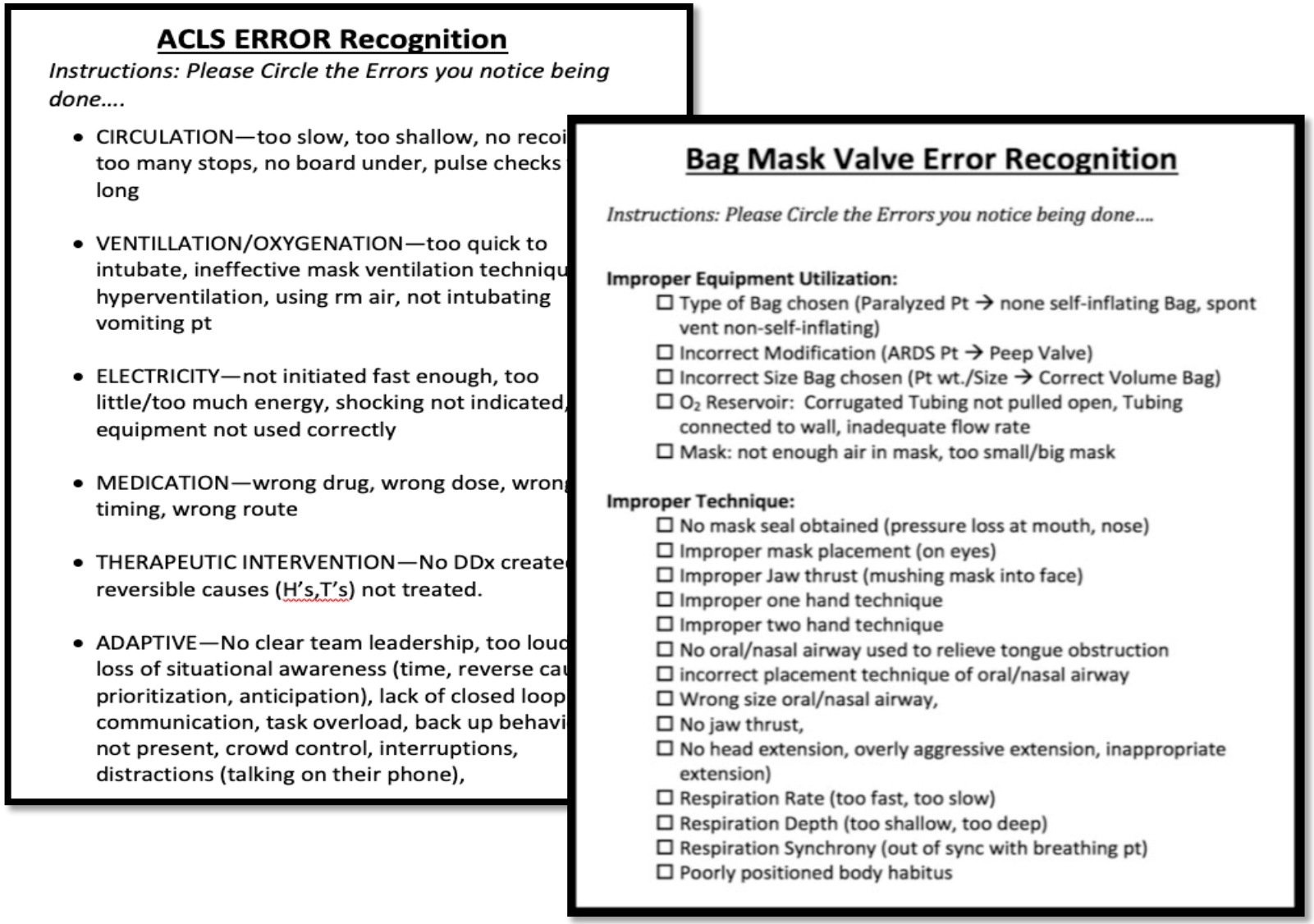
Key Message #5

Any time a system exceeds human capability and/or capacity to do work, errors will occur.

Train humans differently. Not just to avoid errors but to expect errors, to recognize errors, detect them early and enable them to rescue.

Error Management Theory—A Practical Approach

- Just-in-time videos
- Simulation
- EMT checklist
  - obvious errors
  - subtle errors
- Recognition and rescue
- Contain



ACLS ERROR Recognition

Instructions: Please Circle the Errors you notice being done….

- CIRCULATION—too slow, too shallow, no recoi too many stops, no board under, pulse checks long
- VENTILLATION/OXYGENATION—too quick to intubate, ineffective mask ventilation techniqu hyperventilation, using rm air, not intubating vomiting pt
- ELECTRICITY—not initiated fast enough, too little/too much energy, shocking not indicated, equipment not used correctly
- MEDICATION—wrong drug, wrong dose, wron timing, wrong route
- THERAPEUTIC INTERVENTION—No DDx create reversible causes (H's,T's) not treated.
- ADAPTIVE—No clear team leadership, too loud loss of situational awareness (time, reverse cau prioritization, anticipation), lack of closed loop communication, task overload, back up behavi not present, crowd control, interruptions, distractions (talking on their phone),

Bag Mask Valve Error Recognition

Instructions: Please Circle the Errors you notice being done….

Improper Equipment Utilization:

- ☐ Type of Bag chosen (Paralyzed Pt → none self-inflating Bag, spont vent non-self-inflating)
- ☐ Incorrect Modification (ARDS Pt → Peep Valve)
- ☐ Incorrect Size Bag chosen (Pt wt./Size → Correct Volume Bag)
- ☐ O_2 Reservoir: Corrugated Tubing not pulled open, Tubing connected to wall, inadequate flow rate
- ☐ Mask: not enough air in mask, too small/big mask

Improper Technique:

- ☐ No mask seal obtained (pressure loss at mouth, nose)
- ☐ Improper mask placement (on eyes)
- ☐ Improper Jaw thrust (mushing mask into face)
- ☐ Improper one hand technique
- ☐ Improper two hand technique
- ☐ No oral/nasal airway used to relieve tongue obstruction
- ☐ incorrect placement technique of oral/nasal airway
- ☐ Wrong size oral/nasal airway,
- ☐ No jaw thrust,
- ☐ No head extension, overly aggressive extension, inappropriate extension)
- ☐ Respiration Rate (too fast, too slow)
- ☐ Respiration Depth (too shallow, too deep)
- ☐ Respiration Synchrony (out of sync with breathing pt)
- ☐ Poorly positioned body habitus

Thank You!

Oren Guttman, MD, MBA
Ed Asplundh Chief Quality and Patient Safety Officer | Jefferson Health Abington
Enterprise Vice President for High Reliability and Patient Safety | Jefferson Health
Oren.guttman@Jefferson.edu

Healthcare Association of New York State (HANYS)

10,000 Ways You Cannot Make a Lightbulb…
Experiences Implementing HRO in Hospitals

TMF Health Quality Institute

Dec. 7, 2023

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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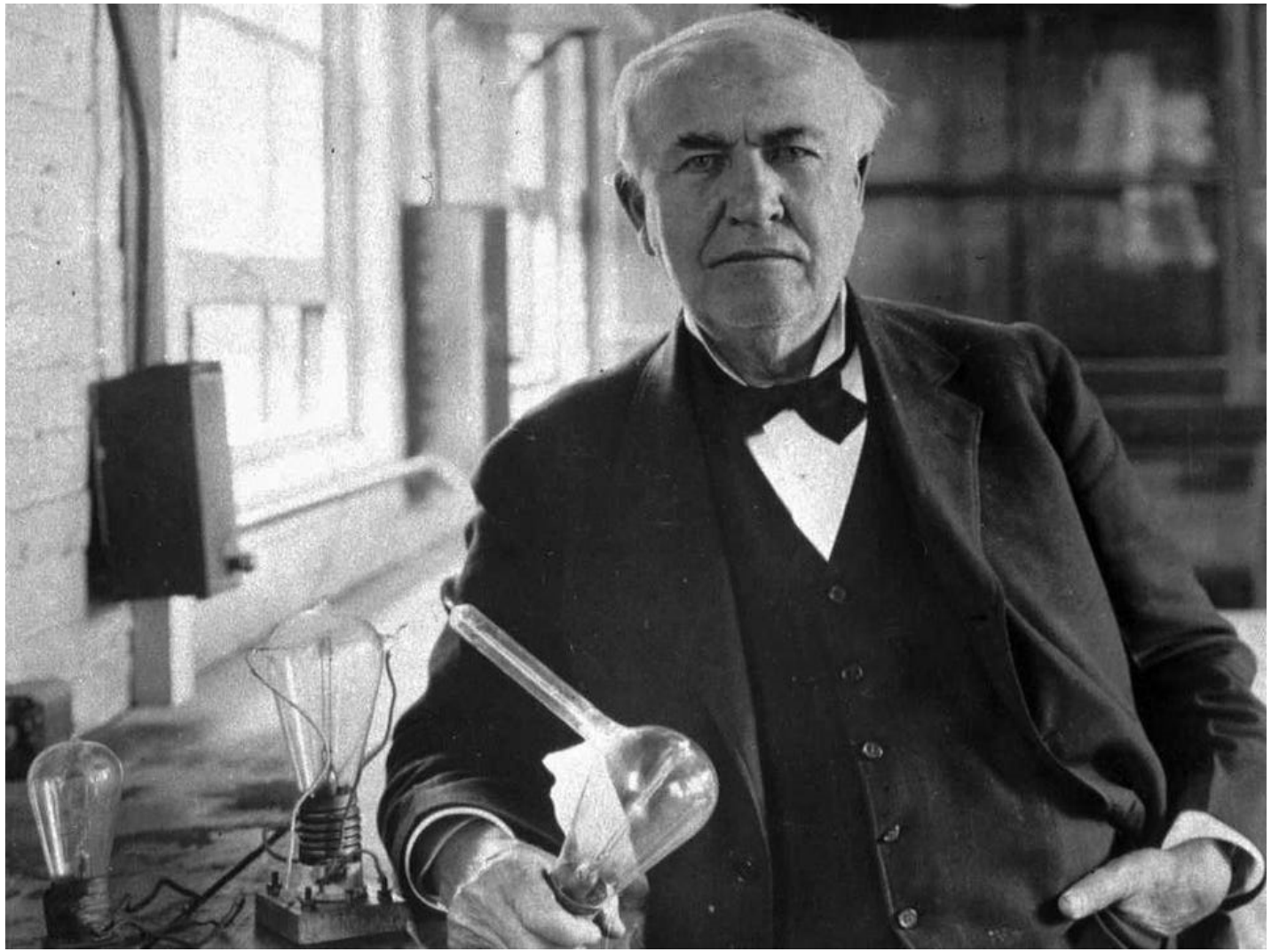
Meet Your Speaker

Russell Kohl, MD, FAAFP

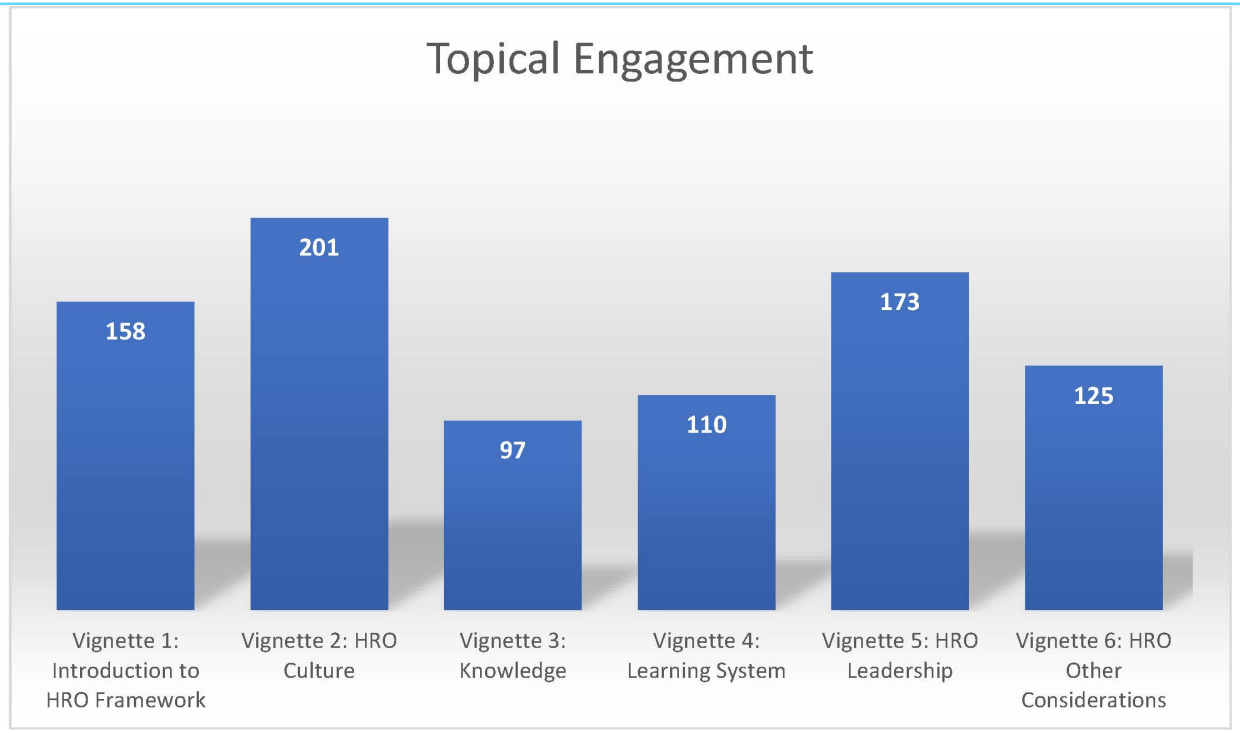
Chief Medical Officer and Chief Operating Officer at TMF Health Quality Institute, a Medicare Quality Improvement Network Quality Improvement Organization (QIN-QIO)



What We Did

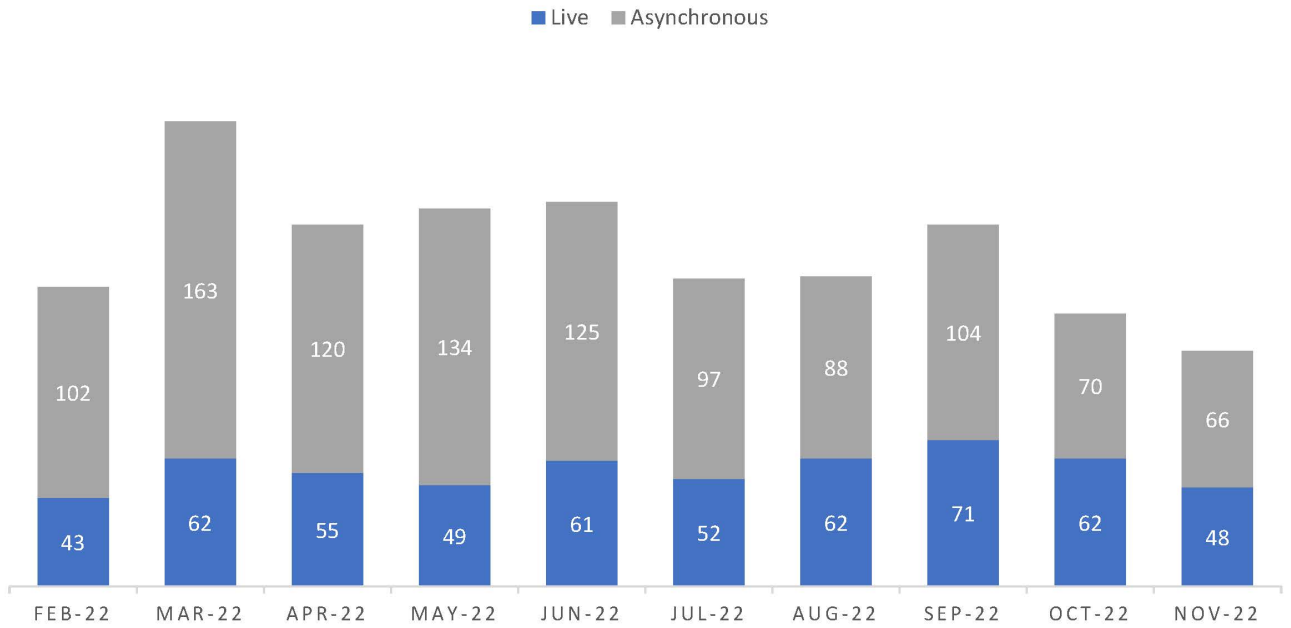
- 2021: **Introduction of HRO in Health Care** *(Partnered with Safe & Reliable Healthcare)*
  - Initial live event
  - Four live monthly events
  - Six on-demand video vignettes
  - Offered Hospital Culture SCORE survey
    - 31 of 181 (17%) hospitals participated
- 2022: **Expanded HRO Education**
  - Ten additional live events
  - Offered Hospital Culture SCORE survey
    - 25 of 181 (7% new) hospitals participated (12 in both 2021 & 2022)
  - Terminated program at end of 2022

On-Demand Vignettes



Title	URL	Date Published	Total Clicks	Live Event Attendance
Introduction to HRO Framework				
Vignette 1: Introduction to HRO Framework	https://youtu.be/zaZQ_EmDQIw	8/2021	158	N/A
Vignette 2: HRO Culture	https://youtu.be/BclhOpOMkIs	8/2021	201	N/A
Vignette 3: Knowledge	https://youtu.be/FeupPo3Sf90	8/2021	97	N/A
Vignette 4: Learning System	https://youtu.be/XUWjgOJncss	8/2021	110	N/A
Vignette 5: HRO Leadership	https://youtu.be/lg1L8yfd7aA	8/2021	173	N/A
Vignette 6: HRO Other Considerations	https://youtu.be/4YHyzGdFlzE	8/2021	125	N/A

Live Sessions Vignettes



2022 TMF HQIC HRO Education Series				
Cultivating Teamwork and Collaboration	https://youtu.be/TUEg8jCwv4Y	2/2022	102	43
Transparency and Data	https://youtu.be/SI5Ifuq9yec	3/2022	163	62
Learning System: Improve, Learn, Implement (Part 1)	https://youtu.be/XF5PplcRC4k	4/2022	120	55
Learning System: Improve, Learn, Implement (Part 2)	https://youtu.be/cxBYmgF_vVg	5/2022	134	49
Leadership: Skills, Activities, Behaviors (Part 1)	https://youtu.be/5zsadjZeMfc	6/2022	125	61
Leadership: Skills, Activities, Behaviors (Part 2)	https://youtu.be/rlX56aLMzcA	7/2022	97	52
Communication	https://youtu.be/Q1toAg8jps0	8/2022	88	62
Using Your SCOR Data to Drive Improvement	https://youtu.be/Z9T51gsPNYo	9/2022	104	71
Burnout	https://youtu.be/wgkezQOdMEk	10/2022	70	62
Creating a Healthy Environment/Rounding for High Reliability	https://youtu.be/PY1Wp2jbIJE	11/2022	66	48

HRO Implementation Strategies

The most implemented HRO strategies included:

- Leadership and staff training in HRO principles and processes
- Active support for developing a culture of safety
  - > Routine sharing of good catches and lessons learned
  - > Increased communication in safety huddles
- Building and using data systems to track progress
  - > Enhanced root cause analysis using electronic tracking systems
- Specific patient safety issue response interventions

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Feedback on Engagement

"What does the data tell us about their interests/priorities?"

Preferred

- Introduction
- Data
- Leadership
- Culture

Disengaged

- HRO Knowledge
- Learning Systems
- Healthy Environment
- Burnout

What We Learned

HRO education and implementation is valuable to hospitals, but it:

- is a lengthy, technical process
- requires engagement of the board of directors
- needs commitment and participation of hospital senior leadership
- involves an internal champion

There is no "Partially Reliable Organization"

Limited Evidence for HRO

"High reliability organizing in health care: still a long way," *BMJ Quality and Safety Journal, 2021.*

- "HRO principles within healthcare are often narrowly enacted within particular silos," with interventions focusing on a specific unit, department or specialty.
- Risk of narrow implementation is that HRO will be considered a nursing concept rather than being applied to the entire organization.
- The article concludes that there is still much work to be done to implement HRO in health care, including research about how things go right every day in health care, a need for increased diversity in tackling reliability issues, and taking a larger industry-wide perspective of health care.

HRO is a means to an end and our measures around it are, at best, intermediate measures.

Our outcome goal is to improve the quality of patient care by reducing unexpected outcomes.

Criteria for Evaluating Strategies

- Time demands of education/training
- Episodic vs. continuous demands
- Financial costs of tools/transition
- Mentor/leadership capabilities
- Degree of cultural alignment
- Current problem identification

Potential Alternative Strategies

- Normal Accident Theory
- Learning Organization Theory
- Just Culture Model

Cultural Foundations of HRO

- **Preoccupation with failure**

  HROs treat anomalies as symptoms of a problem with the system. The latent organizational weaknesses that contribute to small errors can also contribute to larger problems, so errors are reported promptly so that problems can be found and fixed.

- **Reluctance to simplify interpretations**

  HROs take deliberate steps to comprehensively understand the work environment as well as a specific situation. They are cognizant that the operating environment is complex, so they look across system boundaries to determine the path of problems (where they started, where they may end up) and value a diversity of experience and opinions.

- **Sensitivity to operations**

  HROs are continuously sensitive to unexpected changed conditions. They monitor the systems' safety and security barriers and controls to ensure they remain in place and operate as intended. Situational awareness is extremely important to HROs.

- **Commitment to resilience**

  HROs develop the capability to detect, contain and recover from errors. Errors will happen, but HROs are not paralyzed by them.

- **Deference to expertise**

  HROs follow typical communication hierarchy during routine operations but defer to the person with the expertise to solve the problem during upset conditions. During a crisis, decisions are made at the front line and authority migrates to the person who can solve the problem, regardless of their hierarchical rank.

Learning Organization Principles

"A group of people working together collectively to enhance their capacities to create results they really care about."

– Peter Senge, *The Fifth Discipline*

Characteristics of a Learning Organization

- Systems Thinking
- Personal Mastery
- Mental Models
- Shared Vision
- Team Learning

Just Culture Principles

"A culture that balances the need for an open and fair reporting environment with the necessity for accountability in the face of human error. It recognizes that errors will occur and seeks to distinguish between human error, at-risk behavior, and reckless behavior."

– James Reason, *Managing the Risks of Organizational Accidents*

Characteristics of a Just Culture

- Blame Differentiation
- Open Communication
- Continuous Learning

Next Steps in Patient Safety

- Topic-specific affinity groups
- Motivational data dashboards
- Patient safety focus
- Multi-modal options for patient safety
- Board-focused training and development

Thank You!

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TMF Health Quality Institute

Implementing an Incident Decision Tree

Health Quality Innovators (HQI)

December 7, 2023

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Meet the Speaker

Jen Murphy, MHA, CPPS

Senior Consultant

Health Quality Innovators

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Objectives

- Define just culture and fair accountability.
- Describe the components of an incident decision tree.
- Review best practices for implementing an incident decision tree in your hospital.

Principles of HROs

Principles of Anticipation

- Preoccupation with failure
- Reluctance to simplify
- Sensitivity to operations

Principles of Containment

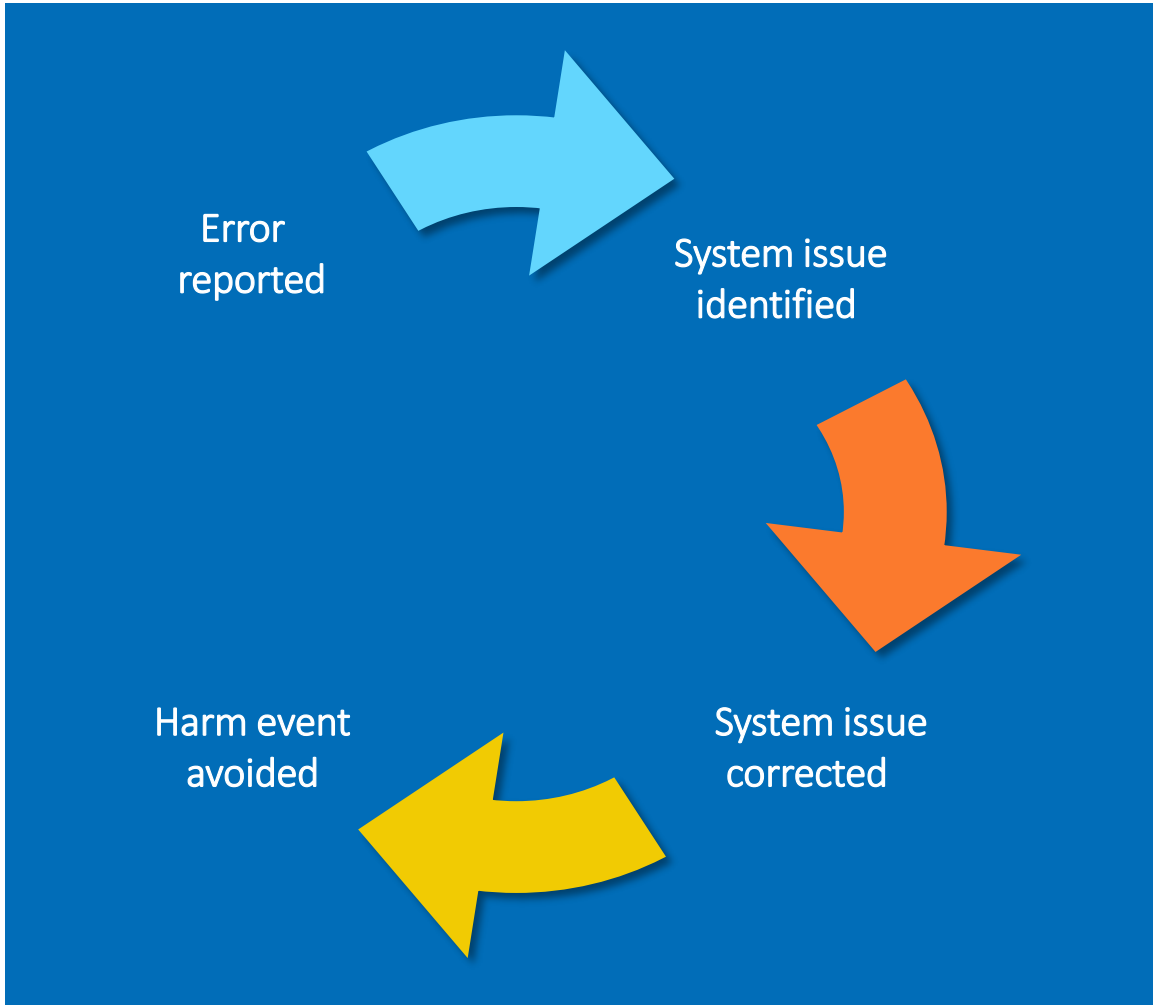
- Commitment to resilience
- Deference to expertise

Quote

"The single greatest impediment to error prevention in the medical field is that we punish people for making mistakes."

- Lucian Leape

Just Culture



- System problems are the main causes
- Encourages reporting of and learning from errors
- Issues are fixed to prevent future harm
- Focus on behaviors and not outcomes

Surveying Level of Just Culture

- "In this unit, staff feel like their mistakes are held against them."
- "When an event is reported, it feels like the person is being written up, not the problem."
- "When staff make errors, the focus is on learning rather than blaming individuals."
- "There is a lack of support for staff involved in patient safety errors."

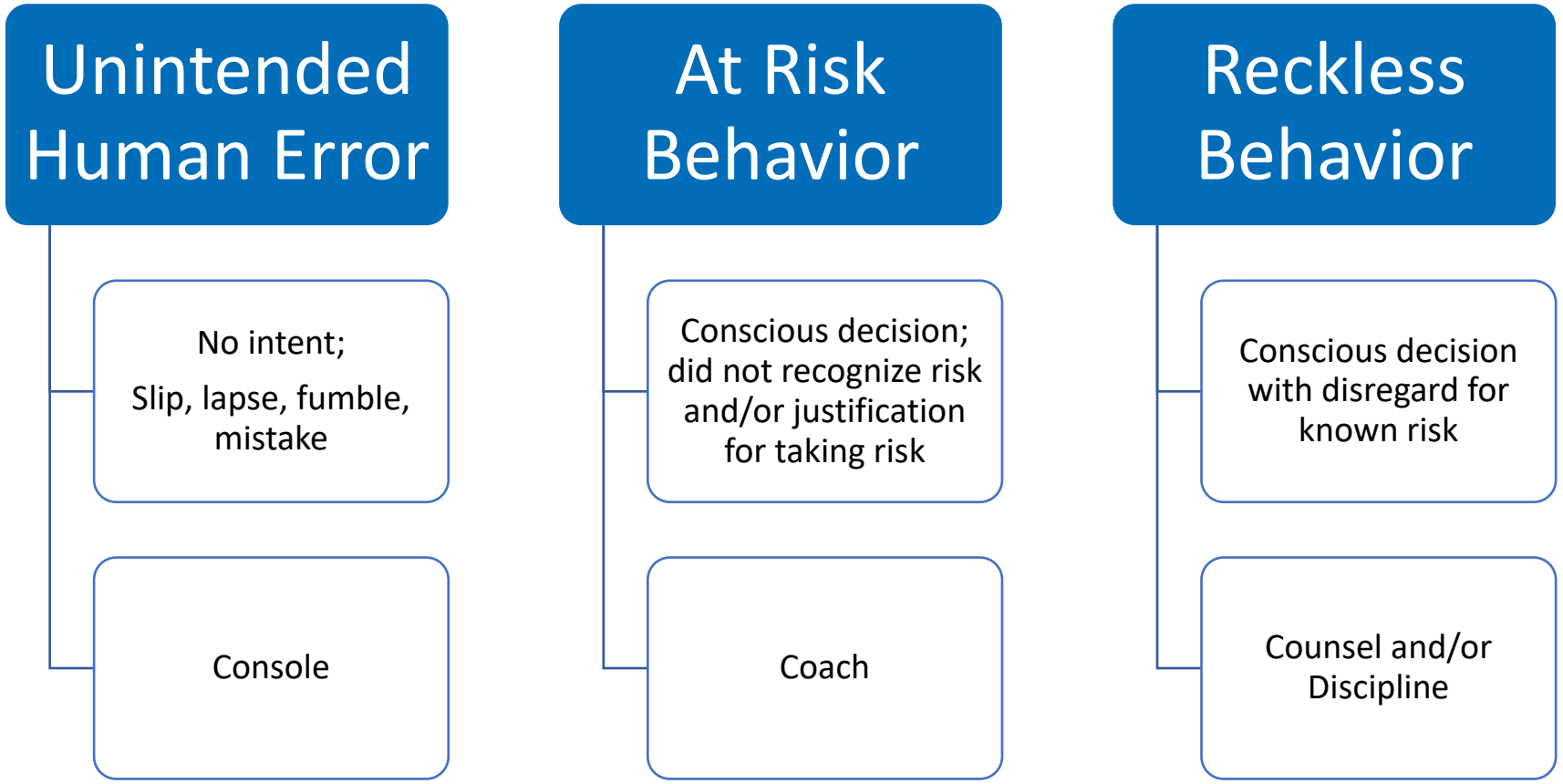
From AHRQ SOPS Hospital Survey

Accountability Spectrum

Fair Accountability

- Taking the appropriate action in response to an error based on the behaviors exhibited and not solely based on the outcome
- May or may not include formal disciplinary action
- May or may not include notification to professional organization or licensing bodies

Behavior versus Outcome

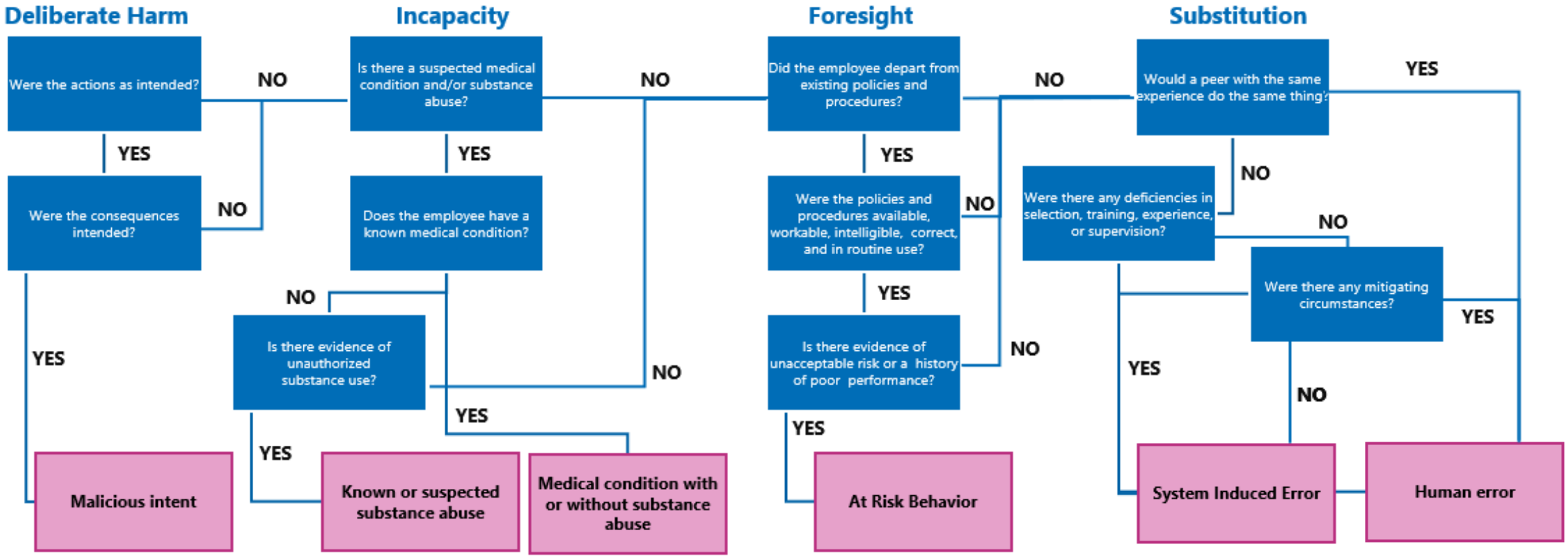


Marx, 2001, Patient Safety and "Just Culture:" A Primer for Healthcare Executives

Incident Decision Tree Background

- Based on the work of James Reason
- Accepts that humans are fallible and will experience errors
- Determines intentionality and riskiness of behaviors
- Determines when disciplinary action is appropriate versus counseling, coaching, or consoling

Incident Decision Tree



Incident Decision Tree Components

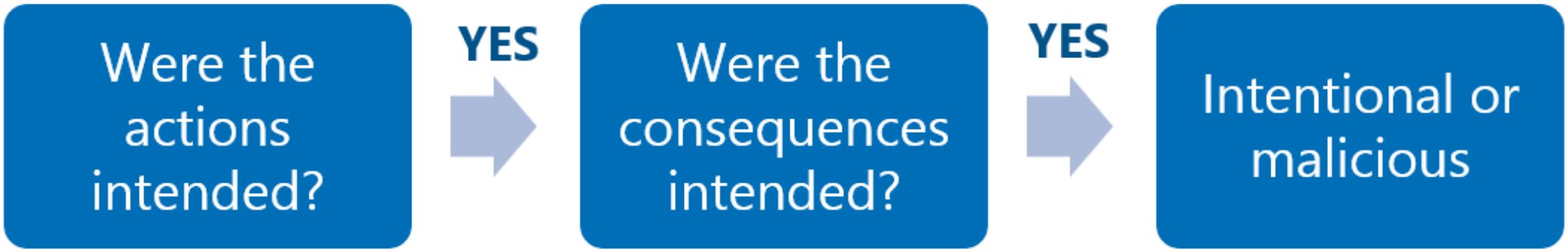
Deliberate harm test

Incapacity test

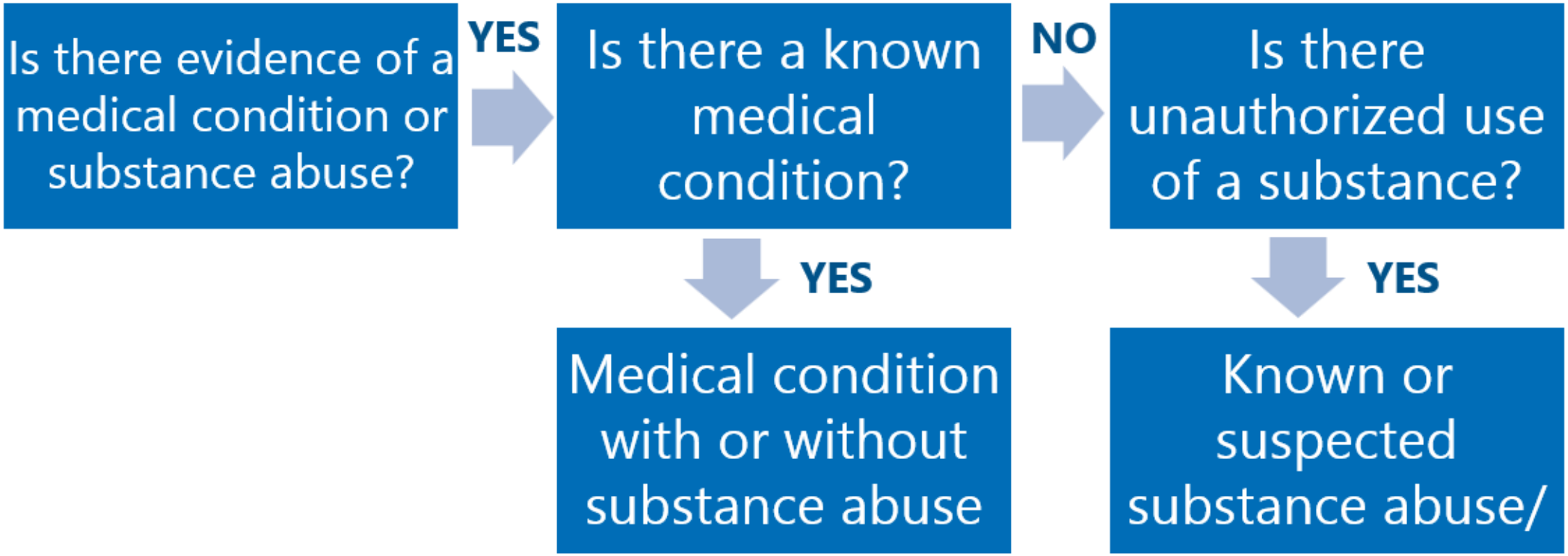
Foresight test

Substitution test

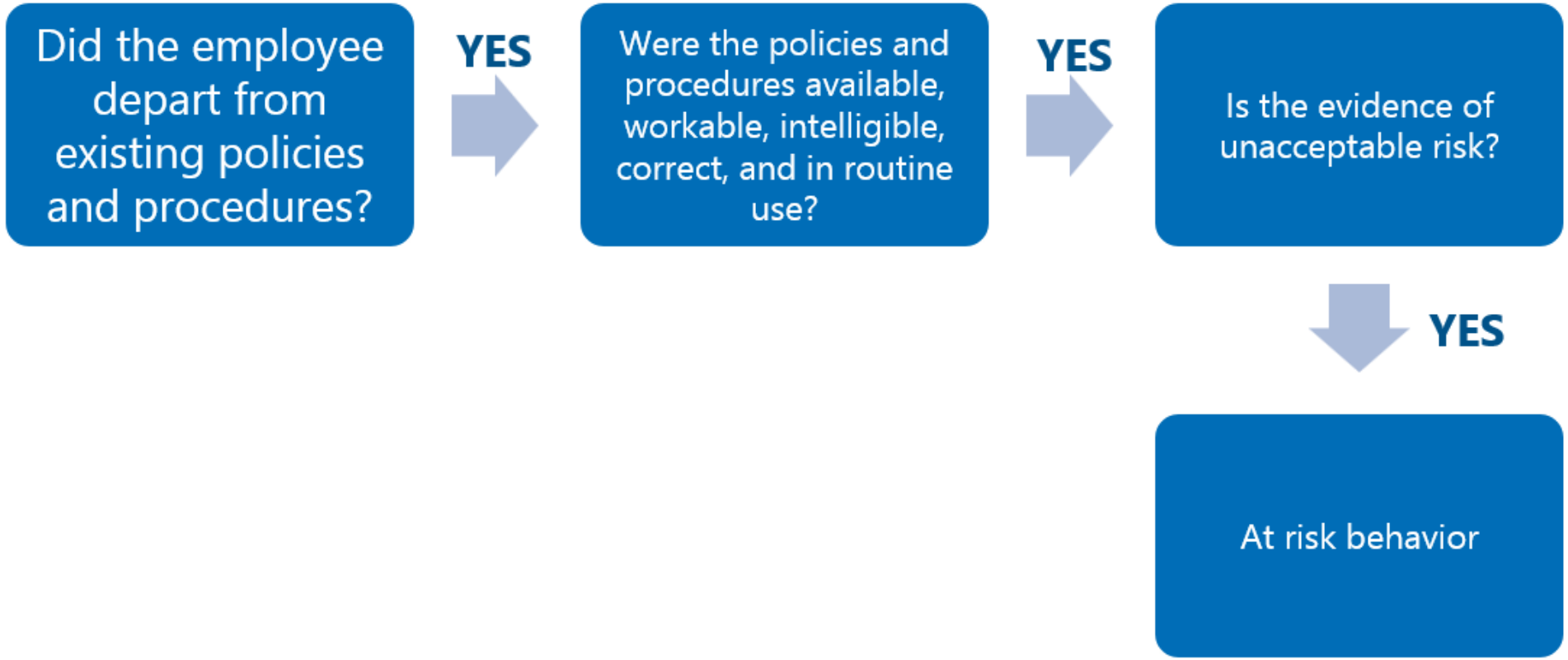
Deliberate Harm Test



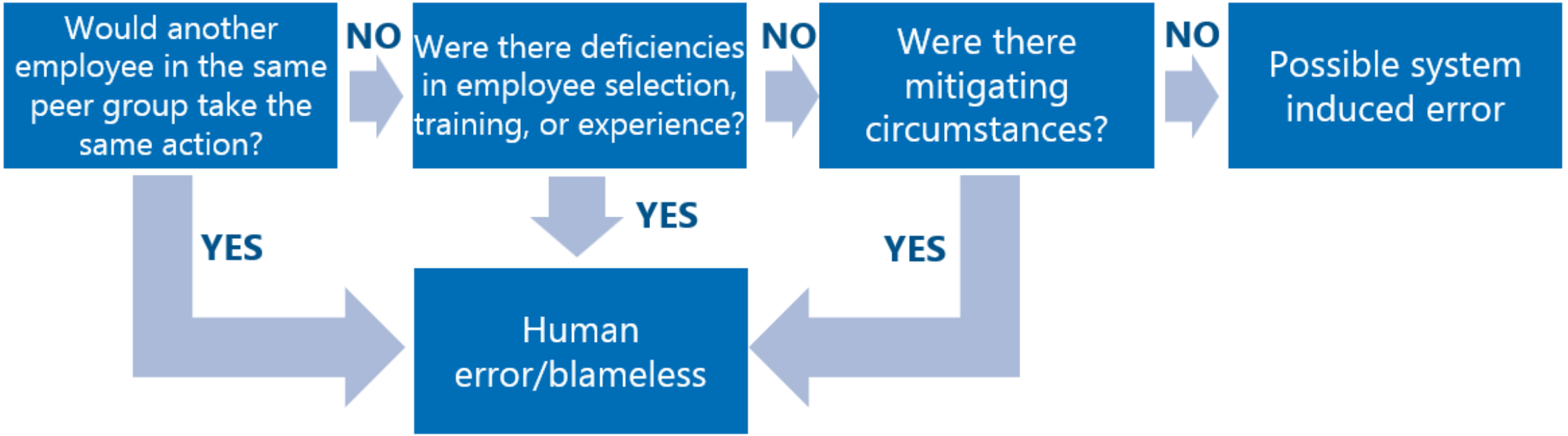
Incapacity Test



Foresight Test



Substitution Test

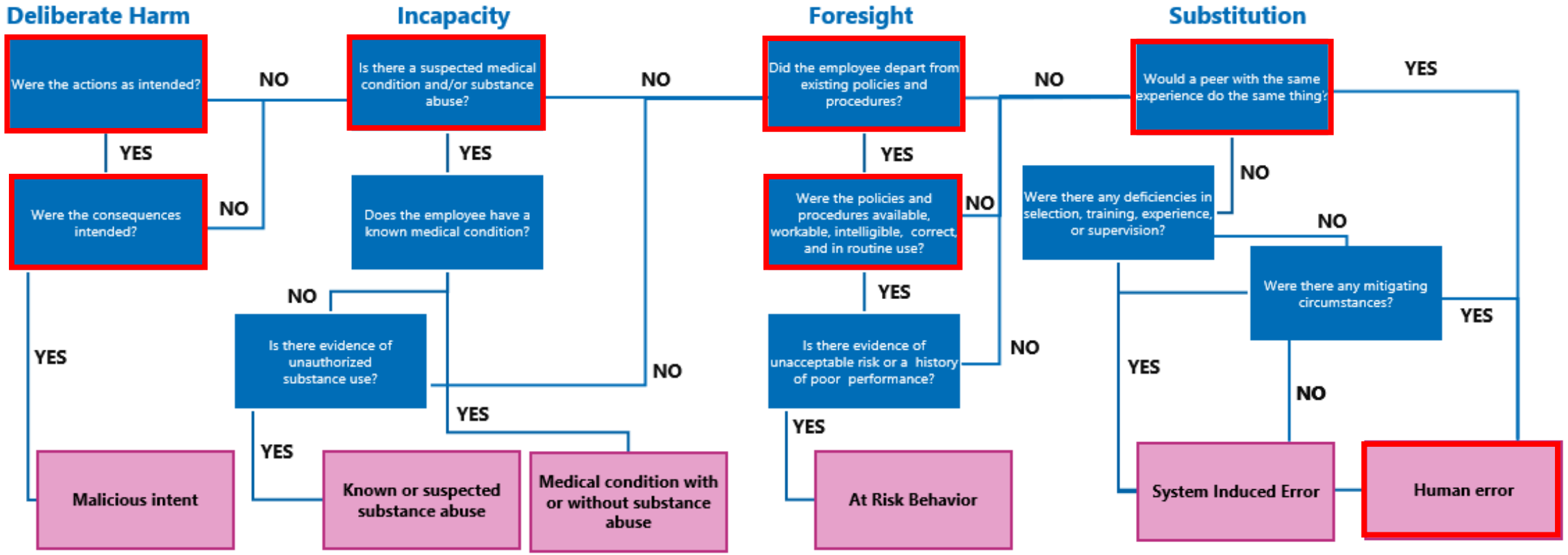


Case Example

A nurse is administering a high-risk medication to a patient and does not adhere to the two-nurse check. The patient experiences an adverse event, and it is discovered that an incorrect dose was given.

After investigating, the nurse manager discovers two-nurse checks are routinely not being conducted by other nurses on the same unit due to low staffing. It has been hard to find another nurse who was not busy and administer medications on time.

Example



Implementing an Incident Decision Tree - Planning

Interprofessional team

C-suite, HR, Quality/Safety, medical staff leadership, professional group representatives

Policy review and revision

Incorporate medical staff

Review of bylaws

Peer review process

Implementing an Incident Decision Tree - Testing

Development of organization specific incident decision tree	Incorporate state reporting guidance and medical staff bylaws
Test case review	Use real events Maintain confidentiality
Identify champions	Utilize safety survey results to identify leaders

Implementing an Incident Decision Tree – Go Live

Piloting

Leadership training and staff education

Launch and monitor

HR reporting

Event reporting system/manager reviews

High Reliability Leadership Series

Visit the HQIN Resource Center for our full High Reliability Organization (HRO) leadership series.

Thank You!

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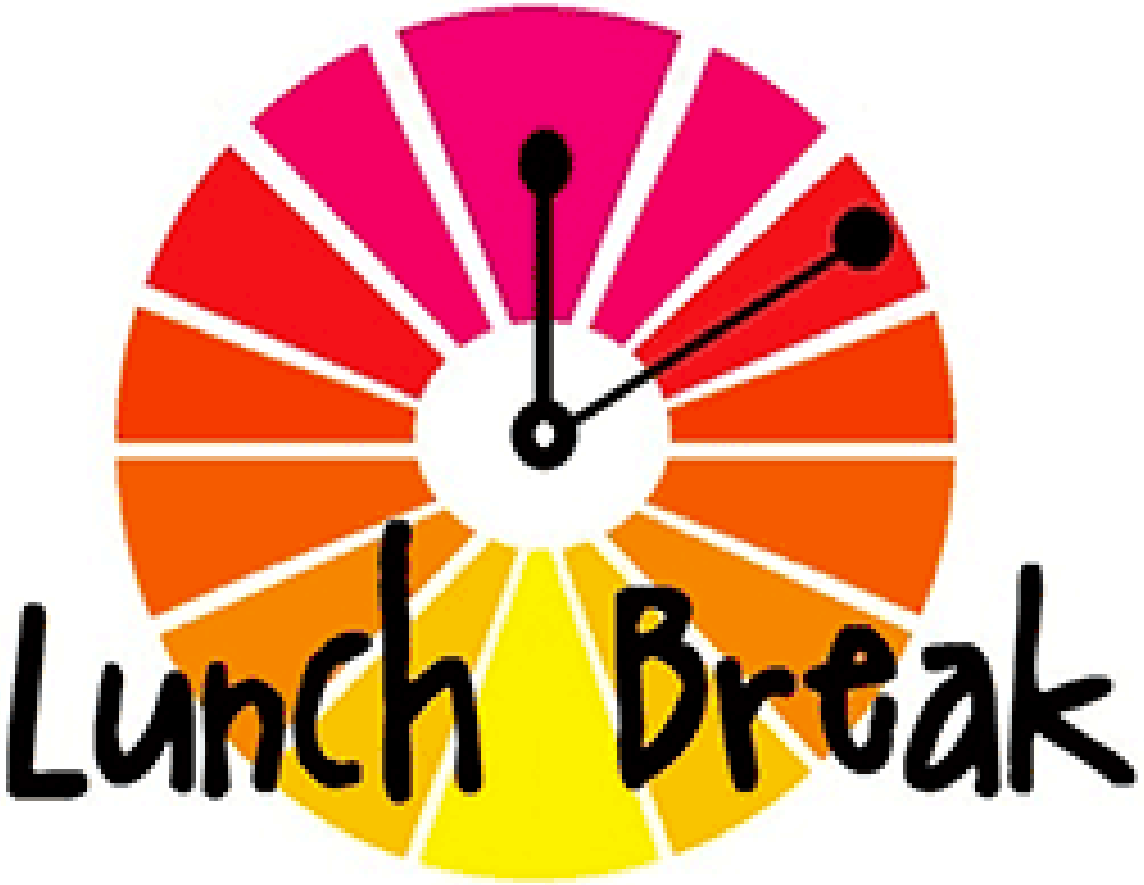
Health Quality Innovators

Polling Questions

Questions to be Answered

1. Has the material shared thus far been helpful to you or your organization?

2. Based on what you have learned this morning, can you take any immediate action over the next 30, 60 or 90 days?


Lunch Break