



MedStar Health

*Knowledge and Compassion*  
**Focused on You**

# Creating a Culture of Safety

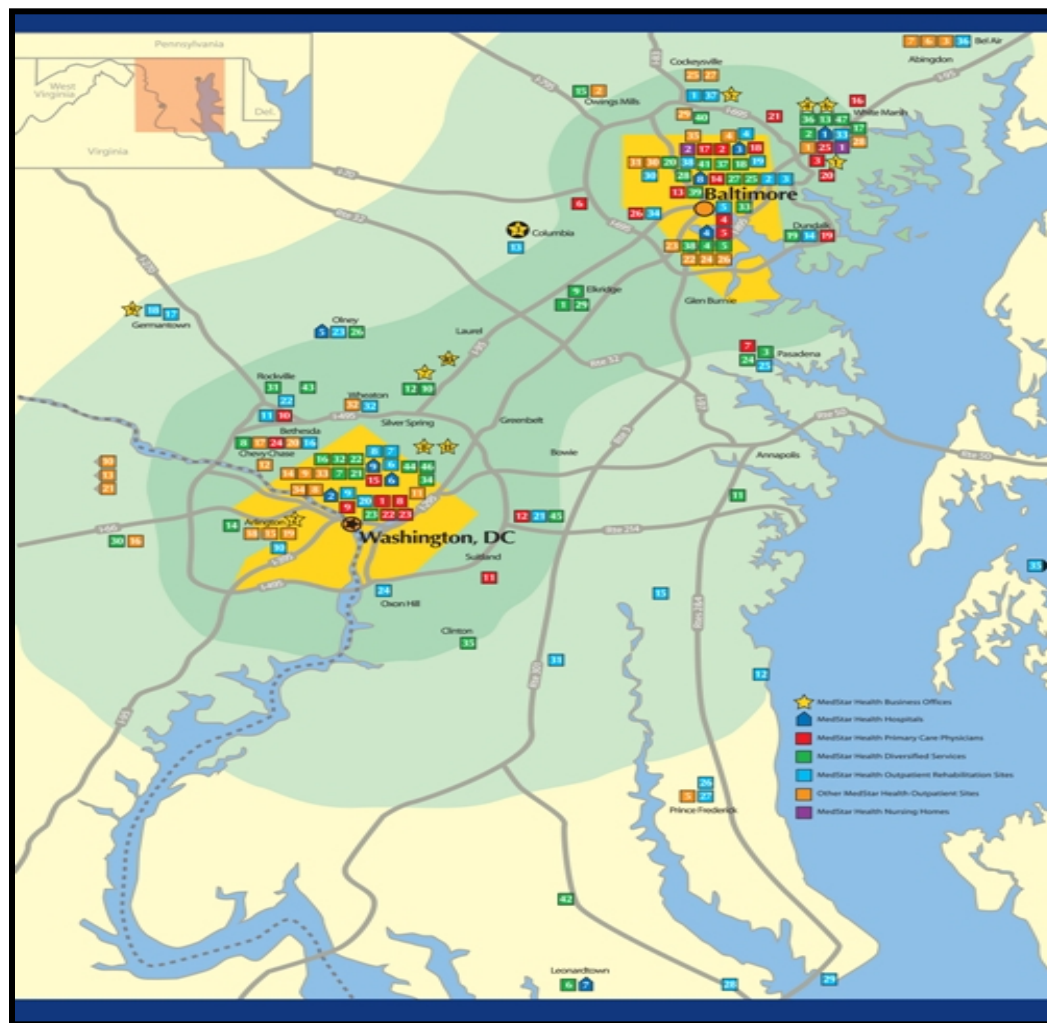
David Mayer, MD

Corporate Vice President for Quality and Safety

MedStar Health

# MedStar Health

- Mid-Atlantic Region
- Large Healthcare System
- Ten hospitals
- Medicaid Managed Care Organization
- Center for Human Factors Engineering in Healthcare
- Research Institute
- Home Health Agency
- 150 Outpatient sites of care
- 26,000 Associates
- 6,700 Physicians
- 162,000 Inpatient Admissions
- 762,000 Inpatient Days
- 1,492,000 Outpatient Visits
- 215,000 Home Health Visits



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# Creating a Culture of Safety

## Educate the Young...

# Creating a Culture of Safety

Educate the Young...  
and Regulate the Old

# Healthcare's *Triple Aim*

Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health and Lower Costs. Maureen Bisognano and Charles Kenney. 2012

- Strong Leadership Commitment
- Transparency
- Patient Engagement
- Interprofessional Teamwork
- Reporting Everything
- Measuring Everything
- Organizational Respect and Support

# Creating a Culture of Safety

- High Reliability
- Transparency
- Patient-Centered, Patient-Engaged, Patient-Driven
- Just Culture
- Respect for fellow workers

# Creating a Culture of Safety

- **High Reliability**





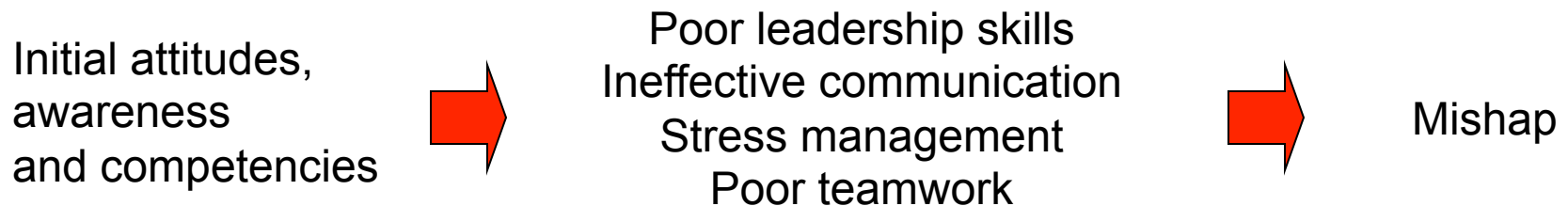


# Creating a Culture of Safety

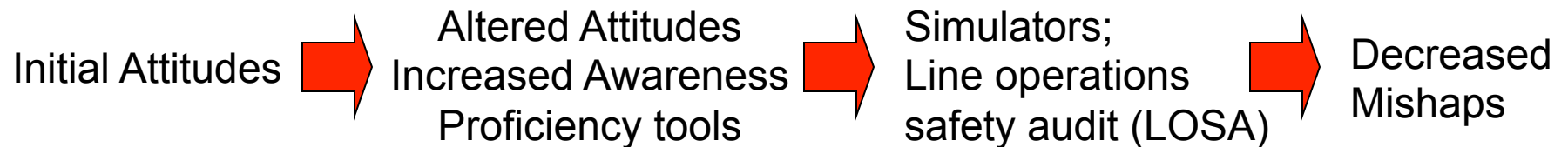
High-reliability organizations, or HROs, share two essential characteristics:

1. They constantly confront the unexpected
2. They operate with remarkable consistency and effectiveness

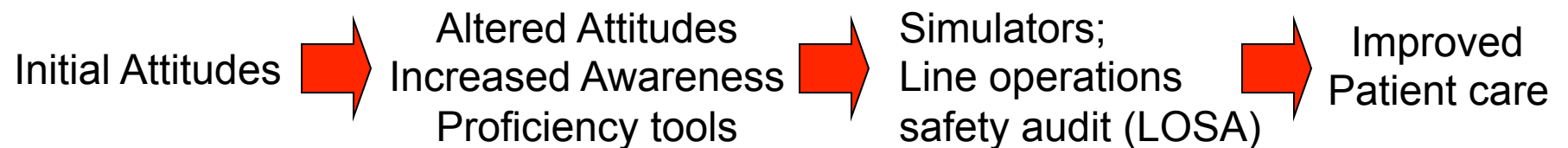
# Improving crew attitudes and competencies in error management

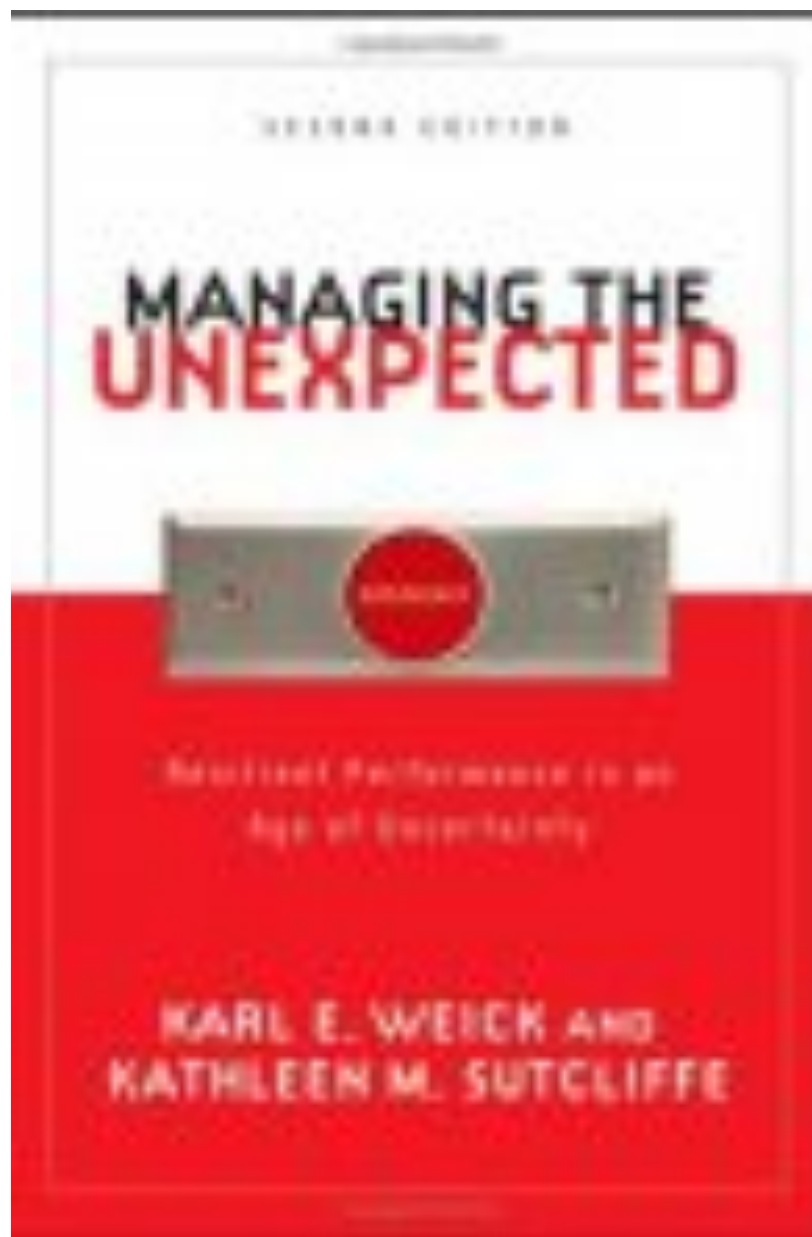


# Improving crew attitudes and competencies in error management



# Improving medical attitudes and competencies in error management



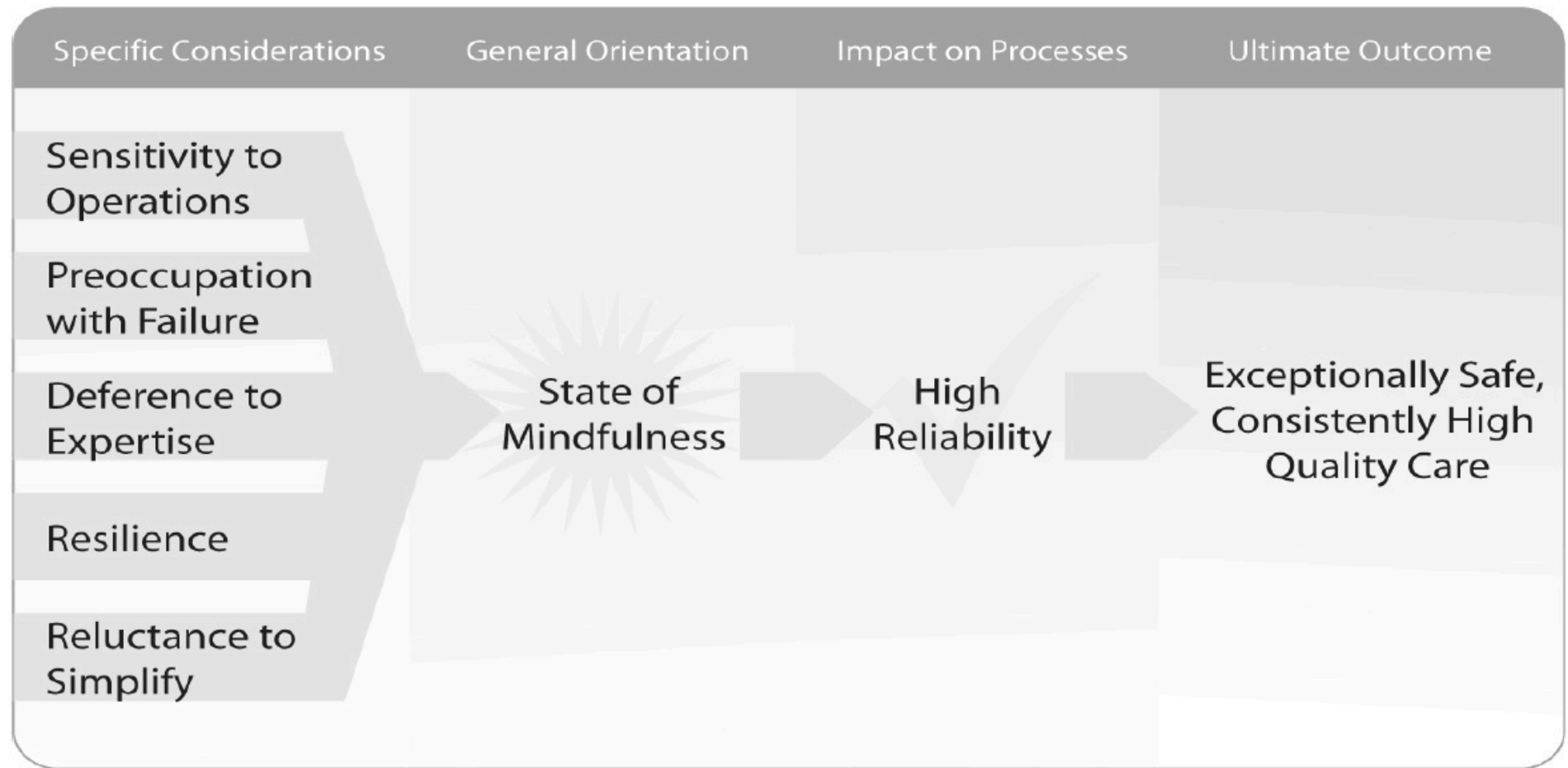


# Creating a Culture of Safety

The five habits of highly reliable organizations:

1. Don't be tricked by your success (Preoccupation with Failure)
2. Defer to your experts on the front line (Deference to Expertise)
3. Let the unexpected circumstances provide your solution (Commitment to Resilience)
4. Embrace complexity (Reluctance to Simplify)
5. Anticipate -- but also anticipate your limits (Sensitivity to Operations)

**Figure 1. The five specific concepts that help create the state of mindfulness needed for reliability, which in turn is a prerequisite for safety**



From AHRQ “Becoming a High Reliability Organization: Operational Advice for Hospital Leaders”

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# Collective Mindfulness

Goals of mindful practice:

- To become more aware of one's own mental processes, listen more attentively, become flexible, recognize bias and judgments, and thereby act with principles and compassion.

# Creating a Culture of Safety

The Ongoing Quality Improvement Journey:  
Next Stop, High Reliability

Mark Chassin and Jerod Loeb

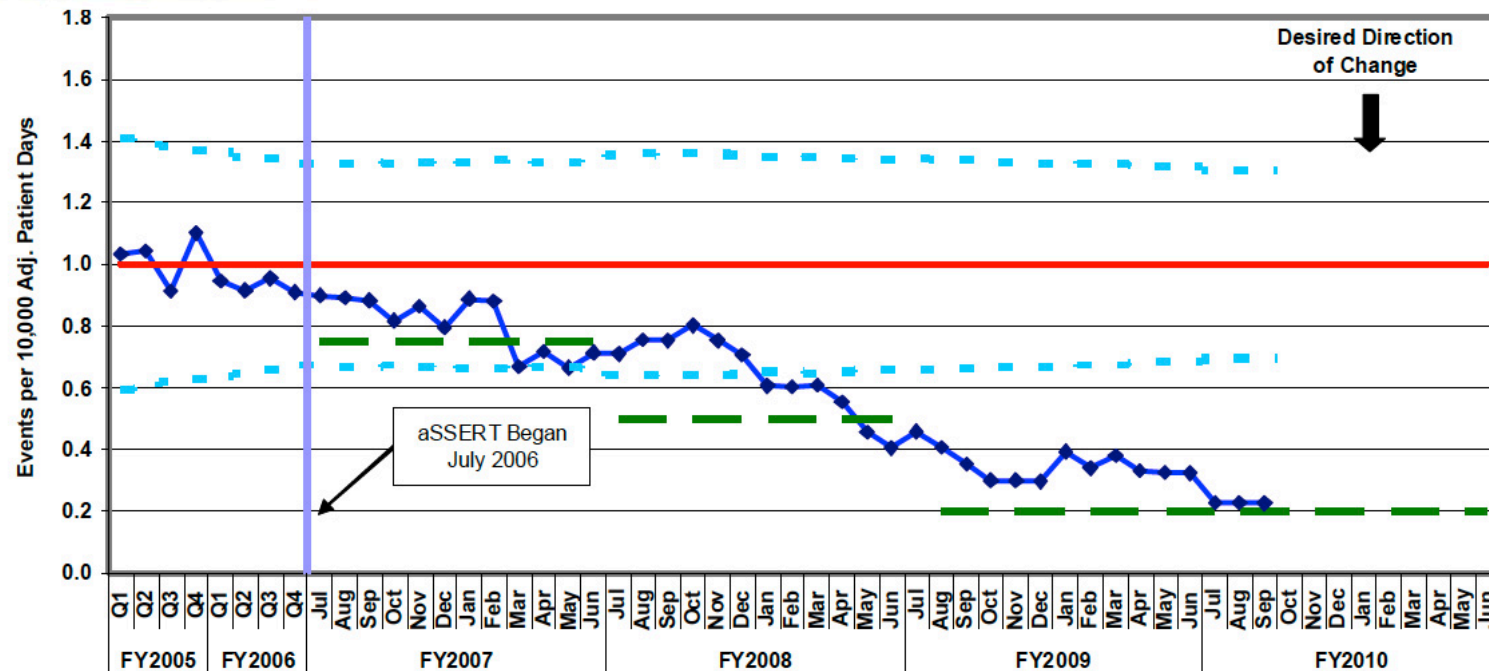
*Health Affairs, 30, no.4 (2011):559-568*

- Leadership
- Safety Culture
- Robust Process Improvement



## Serious Safety Events per 10,000 Adj. Patient Days Rolling 12-Month Average

**SSER** Serious Safety  
Event  
Rate <sup>SM</sup>



\*\* Each point reflects the previous 12 months. Threshold line denotes significant difference from baseline for those 12 months ( $p=0.05$ ).  
 \*\* The narrowing thresholds in FY2005-FY2007 reflect increasing census. Adjusted patient days for FY07 were 27% higher than for FY05.

—◆— SSES per 10,000 Adj. Patient Days  
 — Baseline [ 1.0 (FY05-06) ]  
 — Fiscal Year Goals (FY07=0.75 / FY08=0.50 / FY09=0.20)  
 - - - Threshold for Significant Change

Chart Updated Through 30Sep09 by Bob Carpenter, Legal Dept.

Source: Legal Dept.

# Creating a Culture of Safety

For more information on High Reliability

*Educate the Young* blog --  
[www.educatetheyoung.wordpress.com](http://www.educatetheyoung.wordpress.com)

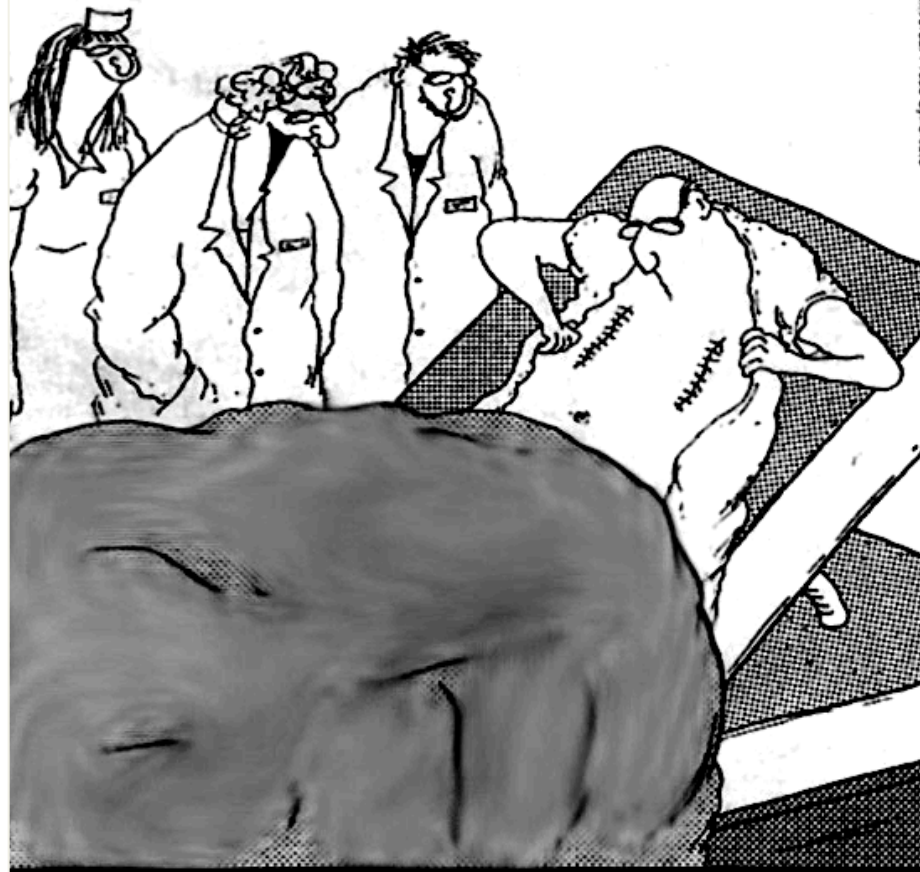
# Creating a Culture of Safety

- High Reliability
- **Transparency**

5-14

McHERSON

© 1996 John McHersson/Ort by Universal Press Syndicate



**"You should've seen the look on our faces  
when we realized that we'd been looking at  
the x-rays backward for the first hour of  
surgery."**

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# Definition of Professionalism

AAMC & NBME:

- Altruism
- Honor and Integrity
- Caring and Compassion
- Respect
- Responsibility
- Accountability
- Excellence and Scholarship
- Leadership

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# Creating a Culture of Safety

- High Reliability
- **Transparent**
  - Transparency in Reporting

# Creating a Culture of Safety

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- **Transparent**
  - Transparency in Reporting
  - Transparency in Outcomes

# Creating a Culture of Safety

- High Reliability
- **Transparent**
  - Transparency in Reporting
  - Transparency in Outcomes
  - Transparency in Communications
    - Informed consent/Shared-decision making
    - Disclosure after harm

# National Recognition of the “Seven Pillars” Program

## News Release

FOR IMMEDIATE RELEASE  
Friday, June 11, 2010

Contact: HHS Press Office: (202) 690-6343  
AHRQ Public Affairs: (301) 427-1855

### **HHS Announces Patient Safety and Medical Liability Demonstration Projects**

**Funds Allocated to Develop, Implement, and Evaluate Patient Safety Approaches and Medical Liability Reform Models**

*Largest federal investment connecting medical liability to quality*



# National Recognition of the “Seven Pillars” Program

## Navigating the Health Care System

### Advice Columns from Dr. Carolyn Clancy



*AHRQ Director Carolyn Clancy, M.D., has prepared brief, easy-to-understand advice columns for consumers to help navigate the health care system. They will address important issues such as how to recognize high-quality health care, how to be an informed health care consumer, and how to choose a hospital, doctor, and health plan. Check back regularly for new columns.*

*[Dr. Clancy](#), a general internist and researcher, is an expert in engaging consumers in their health care.*

[Select for Previous Columns.](#)

## Revealing Medical Errors Helps Chicago Hospitals Build a Safer Health System

The Seven Pillars process works because it spells out and follows steps that we know make a lasting difference in building a safer health system. Reporting, communicating, creating a culture of learning, and other improvements move us closer to identifying and fixing patient safety gaps, rather than simply assigning blame.

# Creating a Culture of Safety

- High Reliability
- Transparent
- **Patient-Centered, Patient-Engaged, Patient-Driven**

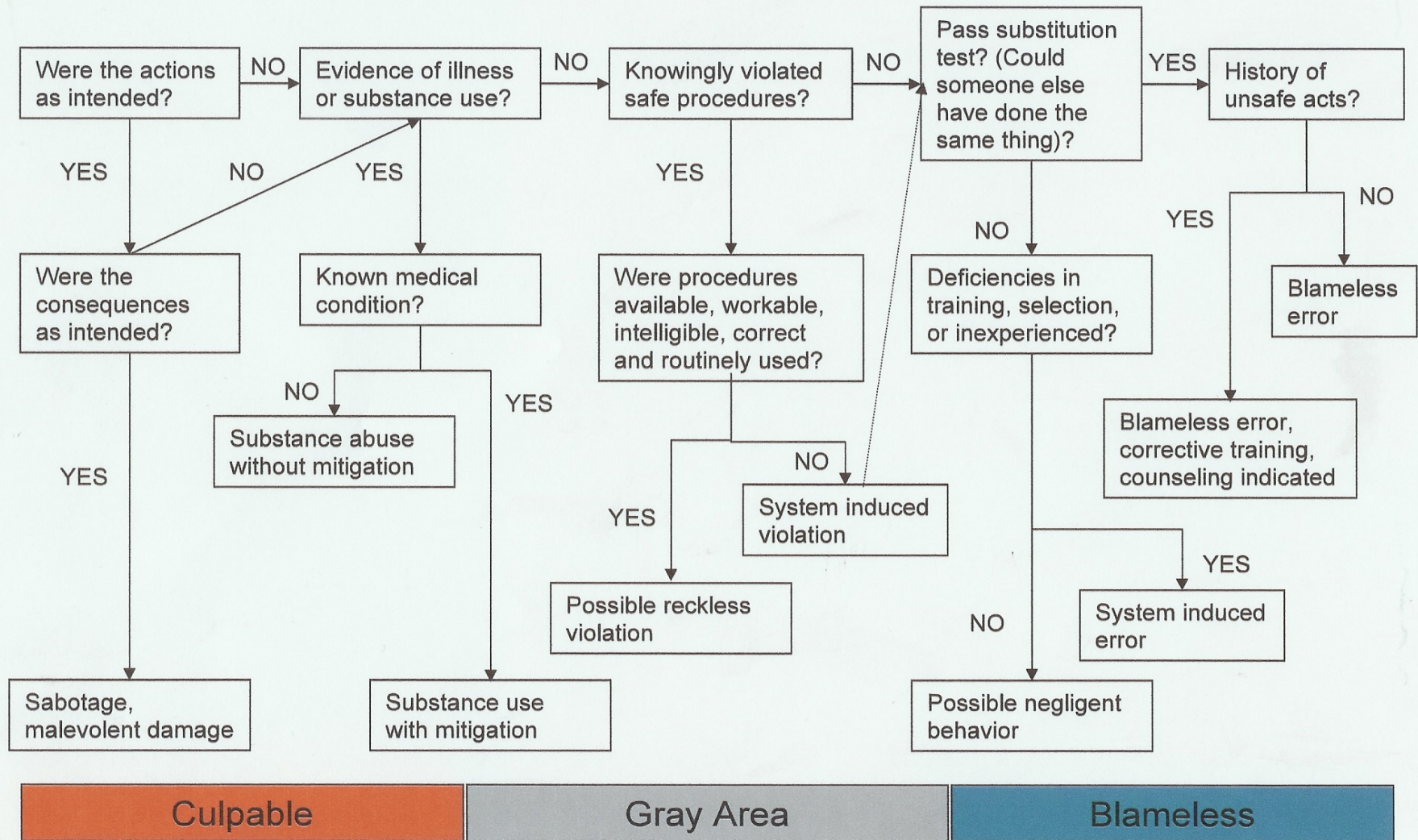
# Creating a Culture of Safety

- High Reliability
- Transparent
- **Patient-Centered, Patient-Engaged, Patient-Driven**
  - Dana Farber
  - Virginia Mason
  - Cincinnati Children's Hospital

# Creating a Culture of Safety

- High Reliability
- Transparent
- Patient-Centered, Patient-Engaged, Patient-Driven
- **Just Culture**

# UNSAFE ACTS ALGORITHM



Adapted from James Reason. (1997). Managing the Risks of Organizational Accidents.



# Creating a Culture of Safety

- High Reliability
- Transparent
- Patient-Centered, Patient-Engaged, Patient-Driven
- Just Culture
- **Respect for fellow workers**

# Paul O' Neill on Safety

Every worker's experience, every day:

- I am treated with respect by everyone else, regardless of position, education or pay
- I have the education and training, the tools, and the support to develop to my full potential
- My work is noticed and appreciated

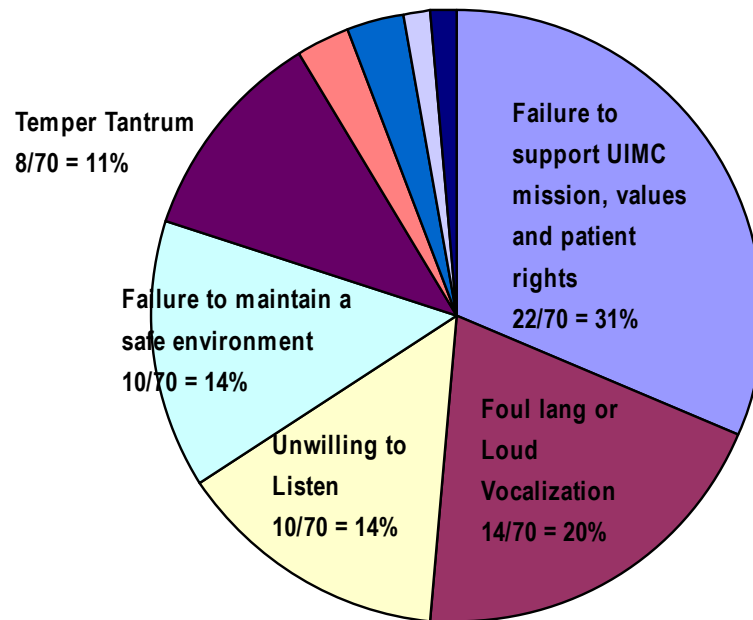


# Creating a Culture of Safety

## CODE OF CONDUCT OBJECTIVE:

UIMC strives to maintain a work environment free from intimidating, demeaning, abusive or disruptive behavior. These behaviors undermine a healthy work environment that supports patient safety and teamwork.

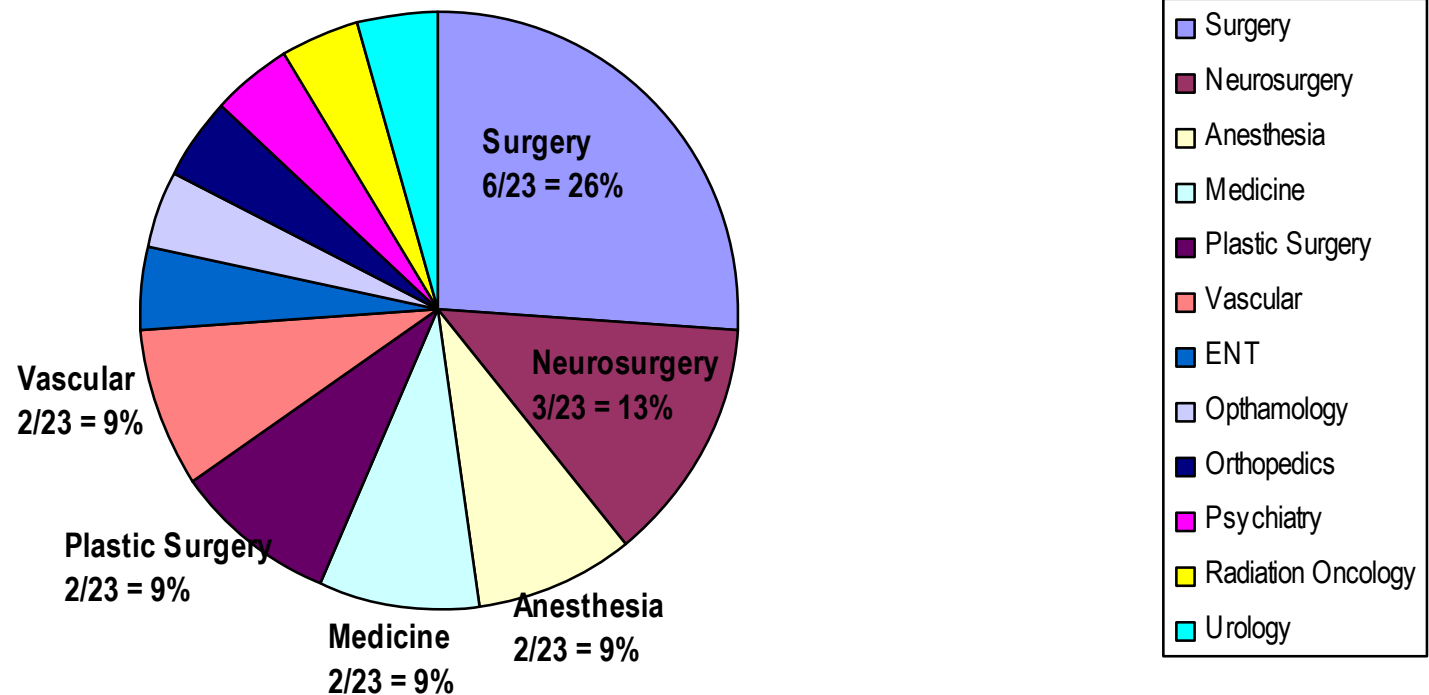
**Number and Percentage of Attending Physician Disruptive Behavior Reports by Category**  
**October 2010 - March 2011**



- Failure to support UIMC mission, values and patient rights
- Foul Language or Loud Vocalization
- Unwilling to Listen
- Failure to maintain a safe environment
- Temper Tantrum
- Inappropriate Body Language
- Violent and Abusive Behavior
- Victimization
- Patient Confidentiality

1 case are pending review

# Number and Percentage of Attending Physician Disruptive Behavior Reports by Department October 2010 - March 2011



# Creating a Culture of Safety

## Humiliation

The emotional response of people (individuals, families, nations, and other groups) to their perception that another person or group has unfairly or unjustly lowered, debased, degraded, or brought them down to an inferior position, that they are not receiving the respect and dignity they believe they deserve.

# Creating a Culture of Safety

## Humiliation

Sense of powerlessness; “power gradient” in place

Wide variation among people in their response to the trauma of humiliation and their ability to either grow from or be damaged by the experience

41

# Creating a Culture of Safety

1. Think about a time when you were humiliated and how you felt when it happened.

# Creating a Culture of Safety

1. Think about a time when you were humiliated and how you felt when it happened.
- 2. Think about a time when you saw one caregiver humiliate another caregiver and how you felt when it happened.**

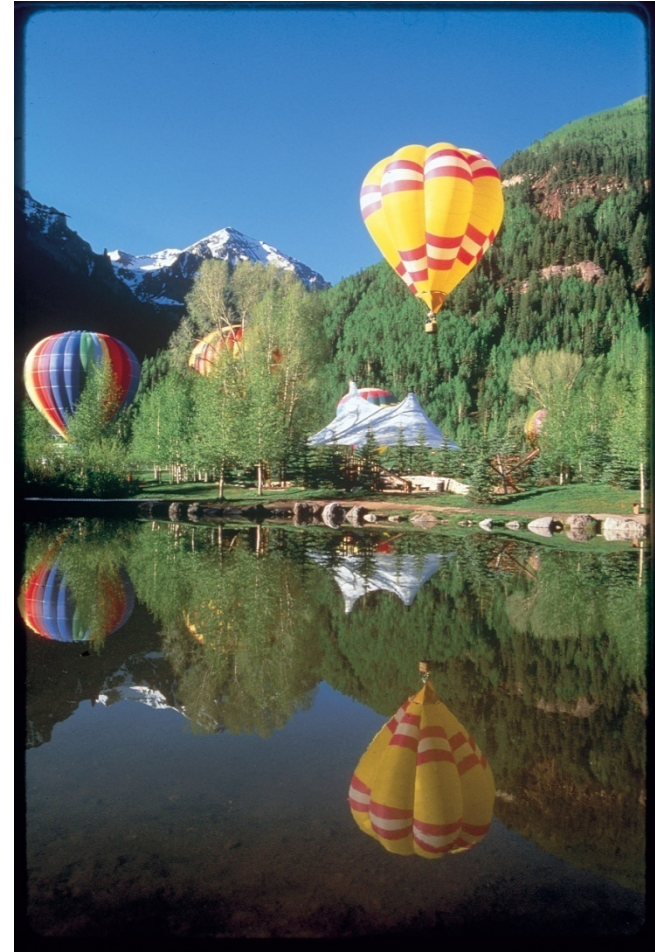
# Creating a Culture of Safety

1. Think about a time when you were humiliated and how you felt when it happened.
2. Think about a time when you saw one caregiver humiliate another caregiver and how you felt when it happened.
- 3. Think about a time when you saw an open, honest and professional discussion between caregivers and how you felt when it happened.**



**Eighth Annual Roundtable:  
“The Power of Change Agents:  
Teaching Caregivers Effective  
Communication Skills to  
Overcome the Multiple Barriers  
to Patient Safety and  
Transparency”  
June 25<sup>th</sup> – June 28<sup>th</sup>, 2012  
Telluride, CO**

Sponsored by TDCF, MedStar Health and  
UIC IPSE



# Telluride Roundtable Vision

To create an annual retreat where stakeholders in patient safety, patient advocacy and health science education come together in a relaxed and informal setting to discuss, develop and refine curricula that support a culture of patient safety, transparency and optimal outcomes in health care.

# Telluride Roundtable Vision

“Teaching Open, Honest and Professional Communication Skills to Overcome the Multiple Barriers to Transparency”

# Telluride Patient Safety Student and Resident Summer Camps

[http://www.solidlinemedia.com/2012/01/  
transparent-health-telluride-patient-safety-  
roundtable-documentary-video-production/](http://www.solidlinemedia.com/2012/01/transparent-health-telluride-patient-safety-roundtable-documentary-video-production/)

# Telluride Summer Camp Goals

## Patient Safety Student Summer Camp learning objectives:

By the end of the Summer Camp, students will be able to:

1. Describe at least three reasons why open, honest and professional communication between caregivers, patients and family members is critical to patient safety, transparency and reducing harm in healthcare.

# Telluride Summer Camp Goals

## Patient Safety Student Summer Camp learning objectives:

By the end of the Summer Camp, students will be able to:

2. Utilize tools and strategies to lead change specific to improving communication and reducing patient harm.

# Telluride Summer Camp Goals

## Patient Safety Student Summer Camp learning objectives:

By the end of the Summer Camp, students will be able to:

3. Implement, lead and successfully complete a Safety/QI project at their institution over the next twelve months.

# ***Leading Change***


## **John Kotter**

- 1) Establish a sense of urgency
- 2) Create the guiding coalition
- 3) Develop a vision and strategy
- 4) Communicate the changing vision
- 5) Empower broad-based action
- 6) Generate short-term wins
- 7) Consolidate gains and produce more change
- 8) Anchor new approaches in the culture

52



*This is a rare film that pulls at the heart and enters the soul, yet also calmly lays out a set of well-reasoned suggestions that allow individuals and institutions to respond to what they have seen, heard and felt."* - Michael L. Millenson  
Health Care Consultant and Author  
Demanding Medical Excellence:  
Doctors and Accountability in the Information Age



**TRANSPARENT HEALTH**

**THE FACES OF MEDICAL ERROR...**  
*from tears to transparency*  
• THE STORY OF LEWIS BLACKMAN •


The Faces of Medical Error...From Tears to Transparency: The Story of Lewis Blackman is the first in a series of educational videos that will address two important issues in health care today - prevention of medical errors and the need for a comprehensive, caring, and compassionate response when care has caused harm.

Lewis entered the hospital to have what was believed to be a low risk surgical procedure. Due to a number of avoidable tragic events over the course of his hospital stay, the outcome was much different than expected. *The Story of Lewis Blackman* is his family's commitment to see beyond their loss and give back to the health care community so we, as caregivers, can find ways to fix our systems and prevent similar harm from occurring to others.

**Educational Program Includes:**

- Full Length Feature Film (Runtime 57 minutes)
- Educational Support Materials
- Reference Materials
- National Quality Forum Safe Practices Applied to Lewis' Story

With an introduction by:



Dr. Lucian Leape  
Harvard School of Public Health

Produced by:  
**Solid Line**  
www.solidlinemedia.com

**TRANSPARENT HEALTH**

**THE FACES OF MEDICAL ERROR...**  
*from tears to transparency*  
www.transparent-health.com

ISBN 978-0-7334-2609-4

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The Faces of Medical Error... From Tears to Transparency: The Story of Lewis Blackman

## The Faces of Medical Error...*from tears to transparency*: The Story of Lewis Blackman

[www.transparentlearning.com](http://www.transparentlearning.com)

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# Telluride Blogs

- Transparent Health -- Telluride  
[www.transparenthealth.wordpress.com](http://www.transparenthealth.wordpress.com)
- <http://runningahospital.blogspot.com/2012/06/telluride-patient-safety-camp-day-1.html>

# Telluride Reflections

Almost all medicals students acknowledged that the four days they spent on patient safety education at the Telluride Summer Camp was more training than they get in their four years of medical school. While all schools have some training in patient safety, it is still infrequent and rarely longitudinal.

# Telluride Reflections

*“I don’t think that I’ve ever thought so much about informed consent as I did today. A discussion about informed consent to the level of detail that we had today needs to be part of all residency training in the first days of orientation and as refresher training later on in training. All physicians can, and should, do much better in providing informed consent.”*

# Telluride Reflections

*“Our discussion on the roles of nurses at different institutions was eye-opening in the sense that many of my peer medical students had very little knowledge about other allied health professionals.”*

# Telluride Reflections

*“The discussion about nursing and doctoring reminded me of conversations I had with fellow classmates at school. We were studying for the NBME Behavioral Sciences exam and joking about the ethical dilemma practice questions we were working on. A common theme that we noticed is that any answer involving soliciting a nurse for help or consulting with a nurse would invariably be wrong...”*

# Telluride Reflections

*...We agreed that answers involving nurses can be crossed off and it would be nice to get one on the test because we could narrow down the answers easier. Almost like how there used to rarely be positive depictions of minorities in the cinema, early medical education is nearly void of positive depictions of nurses.”*





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# Telluride Summer Camp

[http://www.youtube.com/watch?v=FrA4GxCWgjw&feature=player\\_embedded](http://www.youtube.com/watch?v=FrA4GxCWgjw&feature=player_embedded)

Jordan Chanler-Berat