IHI Expedition
Engaging Frontline Teams to Create a Culture of Safety

February 26th, 2013
These presenters have nothing to disclose

Annette Bartley, RN, MS, MPH
Tracy Jacobs, BSN, RN

Expedition Coordinator

Kayla DeVincentis, CHES, Project Coordinator, has worked at IHI since 2009, starting as an intern in the Event Planning department. Since then, Kayla has contributed to the STAAR Initiative, the IHI Summer Immersion Program, and the Expeditions. Kayla obtained her Bachelor’s in Health Science from Northeastern University and brings her interest in health education and wellness to IHI’s Work-Life Wellness Team.
WebEx Quick Reference

- Welcome to today’s session!
- Please use chat to “All Participants” for questions
- For technology issues only, please chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting…

Please send your message to
All Participants
Chat Time!

What is your favorite springtime activity?

Join Passport to:

- Get unlimited access to Expeditions, two- to four-month, interactive, web-based programs designed to help front-line teams make rapid improvements.
- Train your middle managers to effectively lead quality improvement initiatives.

... and much, much more for $5,000 per year!

Visit [www.IHI.org/passport](http://www.IHI.org/passport) for details.
To enroll, call 617-301-4800 or email [improvementmap@ihi.org](mailto:improvementmap@ihi.org).
What is an Expedition?

**ex•pe•di•tion** (noun)
1. an excursion, journey, or voyage made for some specific purpose
2. the group of persons engaged in such an activity
3. promptness or speed in accomplishing something

Expedition Support

- All sessions are recorded
- Materials are sent one day in advance
- Listserv address for session communications: SafetyExpedition@ls.ihi.org
  - To add colleagues, email us at info@ihi.org
Tracy Jacobs, BSN, RN, in health care quality improvement.

Centers focused on improving chronic disease and inpatient-focused initiative and a ten-year work with Improving Patient Care, a wide-reaching improvement program within the Indian Health System, and the ongoing “Achieving Excellence in Primary Care” call series. She has worked on several large IHI collaborative improvement projects, including the Transforming Care at the Bedside inpatient-focused initiative and a ten-year collaborative initiative with the Health Resources and Services Administration’s Federally Qualified Health Centers focused on improving chronic disease and preventive care services for the nation’s underserved populations. Ms. Jacobs has 12 years of experience in health care quality improvement.
Today’s Agenda

- Introductions & Setting the Scene
- Background and Context of Safety
- The Current State of Harm
- Fundamental Principles
- The Model for Improvement
- Homework for next session

How to Get the Most From This Expedition

- “All teach, All Learn” philosophy
- Join and participate on ALL calls
- Use the 50 mile rule
- Test, test, test
- Share what you have learned (failures and successes)
- Participate in the listserv discussion
  - Listserv address: SafetyExpedition@ls.ihi.org
What Can You Expect of Us?

- Interactive WebEx sessions
- Prompt responses to your listserv questions (when needed)
- E-mail and phone contact info
- We are learning from you and with you

Our Intent – Overall Program Aim

- Understand the discipline of patient safety and its role in minimizing the incidence and impact of adverse events, and maximizing recovery from them
- Create a culture of safety amongst frontline healthcare teams that protects all
- Active participants/homework assignments
- Applying the theory in practice
- Sharing the learning
Expedition Objectives

At the end of the Expedition each participant will be able to:

- Describe background and context of patient safety
- Identify tools which will help to improve communication and teamwork, essential to building culture
- Apply a range of simple tools and improvement methods for engaging staff in improving patient safety and measuring improvement
- Identify strategies for managing conflict management, including: appropriate assertion and critical language
- Describe strategies for involving patients and family members in preventing harm

Schedule of Calls

Session 1 – Background and Context of Safety
Date: Thursday, February 28, 1:00 PM – 2:30 PM ET

Session 2 – Essentials of Teamwork
Date: Thursday, March 14, 1:00 PM – 2:00 PM ET

Session 3 – Effective Communication
Date: Thursday, March 28, 1:00 PM – 2:00 PM ET

Session 4 – Measurement of Adverse Events
Date: Thursday, April 11, 1:00 PM – 2:00 PM ET

Session 5 – Tools and Techniques for the Frontline Staff
Date: Thursday, April 25, 1:00 PM – 2:00 PM ET

Session 6 – Engaging Patients and Families in Preventing Harm
Date: Thursday, May 9, 1:00 PM – 2:00 PM ET
Faculty

Annette J. Bartley RGN, BA (Hon) MSc, MPH,
Programme Director, The Health Foundation's Safer Patient Network, UK, is a registered nurse with over 30 years of health care experience. In 2006 she was awarded a one-year Health Foundation Quality Improvement Fellowship at the Institute for Healthcare Improvement, during which time she also completed an MPH at Harvard University. Ms. Bartley was faculty lead for the Welsh pilot of Transforming Care at the Bedside (TCAB) and now advises the Welsh Assembly Government as TCAB spreads across Wales. She is a founding member of the Welsh Faculty for Healthcare Improvement and serves as faculty for the IHI TCAB Collaborative, the Wales 1,000 Lives plus Transforming Care programme, the South West Quality and Patient Safety Improvement programme, the National Tissue Viability pressure ulcer prevention pilot programme for Quality Improvement Scotland, and the Kings Fund hospital pathways programme.

Background and Context of Safety
Patient Safety

- The Institute of Medicine (IOM) study “To Err is Human; Building a Safer Healthcare System”
- Adverse events occur in 2.9 to 3.7% of all hospitalizations
- Between 44,000 to 98,000 patients die a year as a result of medical errors

Patient Safety

“Freedom from accidental injury” – a more than reasonable expectation for those accessing the health care system.

The US Institute of Medicine (1999)

‘Safety’ is not a single event or even something that we “do.” Safety is a notion which should inform our every action.

Phil Higton Terema
Institute of Medicine Aims

- Safe (no needless deaths)
- Timely (no unwanted waiting)
- Efficient (no waste)
- Effective (no needless pain or suffering)
- Patient and family centred (no helplessness)
- Equitable (for all)

*IOM= Crossing the Quality chasm 2001 (IHI)*

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The Reality in Practice

*Cartoon showing a patient and a nurse in a hospital setting. One patient is handed a booklet while saying, "You don't look so good, should I call the nurse?" The nurse responds, "I am the nurse!"*
What Exactly is Patient Safety?

- Patient safety is a discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.

Reliability in Healthcare

- Healthcare is a high hazard industry
- Approximately 10% (900,000) of patients admitted to hospital experience a patient safety incident
- 72,000 of these incidents/adverse events contribute to the death of patients
- Over 2,000,000 reported patient safety incidents/adverse events UK (NPSA, 2008)
- Many go unrecognised/hidden/accepted
- Significant impact on costs in healthcare
Patient Safety – The Facts

1. Cardiovascular Disease
2. Cancer
3. Respiratory Disease
4. Adverse Events

Do You Really Understand Where ‘Harm’ Lies?
Pre-work

- We would welcome a couple of volunteers to share their learning from their pre-work
- Please raise your hands

- We asked you to review the last 5 adverse events/patient safety incidents on your unit/ward/department
  - What did you learn that was new?
  - What surprised you?
  - What will you do differently as a result?

Harm

- Every system is designed to produce the outcome it gets
- We have systems of care designed to produce certain levels of harm
- These levels of harm have become acceptable as a property of the system (normalisation of the abnormal)
- All harm is theoretically preventable
IHI Definition of Harm

Unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or that results in death.

Accepting the Harm Burden

Adverse Event vs. Error

- “Adverse event” describes harm to the patient, and is thus outcome focused
- “Error” definition bears upon concept of preventability, and is therefore process-focused
- Relationship between errors and adverse events:
Adverse Events Are Best Defined From the Viewpoint of the Patient

Would I be happy if the event happened to me?

An adverse event is harm to the patient from the viewpoint of the patient.

Error

- **a simple definition is:**
  "Doing the wrong thing when meaning to do the right thing."
  Runciman

- **a more formal definition is:**
  “Planned sequences of mental or physical activities that fail to achieve their intended outcomes, when these failures cannot be attributed to the intervention of some chance agency.”
  James Reason

  - **Error of execution**
    Failure of a planned action to be completed as intended

  - **Error of planning**
    Use of a wrong plan to achieve an aim
Error and Outcome

Error and outcome are not inextricably linked:
- Harm can befall a patient in the form of a complication of care without an error having occurred
- Many errors occur that have no consequence for the patient as they are recognized before harm occurs

Bob Wachter on Patient Safety 2013

“I’ve never been more worried about the safety movement than I am today. My fear is that we will look back on the years between 2000 and 2012 as the Golden Era of Patient Safety, which would be okay if we’d fixed all the problems. But we have not.”

1. Clinical Burnout: “the blizzard of new initiatives – all well meaning but cumulatively overwhelming – thrust at busy clinicians has created overload”
2. Strategic repositioning of priorities
Despite Best Efforts

- Existing good practice
- Yet still...
- Reactive - focus on mitigation
- Root Cause Analysis
- Lots of information but ...?
- Delays in closing the loop
- Failure to identify and learn from adverse events
- Disconnect in clinical practice
- Lack of local ownership

TOO MUCH, TOO MANY, LIMITED RESOURCES

Why Do Things Fall Through The Cracks?

- System failures
- Communication failures/styles
- Inherent human limitations
  - Limited short term memory
  - Negative effects of stress
  - Fatigue
  - Multitasking, interruptions, distractions
Systemic Migration to Boundaries

INDIVIDUAL BENEFITS

Driving 80 mph – the ‘illegal-illegal’ space

Driving 60 mph - the ‘Illegal-normal’ space (for almost all of us!)

The posted speed limit is 50 mph - the ‘legal’ space

Perceived vulnerability

Belief Systems.

Life Pressures

Systemic Migration to Boundaries

INDIVIDUAL BENEFITS

Only wash hands on audit days

Handwashing when patient has MRSA

Wash hands every patient, every time

Perceived vulnerability

Belief Systems.

Life Pressures
Why Measure Harm?

- The underpinning philosophy of healthcare is to do no harm, and therefore an indication of the level of harm already in a system (a baseline) and a measure of the impact of changes on the amount of harm in that system is vital.
- Secondly, if you are to improve a process and thus reduce harm you need to understand both the level of harm already in the system and also the nature of the problem, namely what is the type of harm and where is it occurring?

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Reporting

- Despite best efforts...
- Traditional reporting of errors, incidents, or events does not reliably occur in the best of cultures in healthcare
- Voluntary methods frequently underestimate events and concentrate on what is interpreted as being preventable
- Tools like the Global Trigger Tool easily identify events without complex technology
**Root Cause Analysis**

**Pro’s**
- A rigorous, confidential approach to answering:
  - What happened?
  - Why did it happen?
  - What are we going to do to prevent it from happening again?
  - How will we know that our actions improved patient safety?

**Cons**
- Too late
- After the event
- Local ownership?
- Closing the loop
- Timeliness of feedback
- Timeliness of preventative action

**Understanding Harm**
- Staff Incidence/event Reporting
- Root Cause Analysis
- Serious Incident Review
- Global Trigger Tool
- Mortality Reviews
- Patient Feedback
- Data for Improvement
Local Ownership of Data

The Swiss Cheese Model

James Reason
Situations Associated with Increased Risk of Error

- Unfamiliarity with the task*
- Inexperience*
- Shortage of time
- Inadequate checking
- Poor procedures
- Poor human equipment interface

Vincent

* Especially if combined with lack of supervision

Fundamental Principles of Patient Safety

- Prevention
- Detection
- Mitigation
Key Factors in Improvement

- Leadership & Culture*
- Teamwork
- Human factors
- Inter-professional communication
- Improvement capacity and capability
- Local ownership
- Reliable care processes
- Partnership with patients and families

* [http://www.ted.com/talks/drew_dudley_everyday_leadership.html](http://www.ted.com/talks/drew_dudley_everyday_leadership.html)

Culture: A workable definition

Shared values (what is important) and beliefs (how things work) that interact with an organization’s structure and control systems to produce behavioural norms (the way we do things around here)

James Reason
Safety Culture Defined

“That assembly of characteristics and attitudes in organisations and individuals which establishes that, as an overriding priority, nuclear plant safety issues receive the attention warranted by their significance.”

“Safety Culture” – (term becomes publicly known as a result of this report)

Paul O’Neill

- Non-Negotiable Mutual Respect
- The tools to do the job
- Acknowledgement of a job well done.

Successful organizations define culture and act out their culture

Organizations are made up of a collection of subcultures

The Culture of Patient Safety is:

- An accountable culture
- A culture of learning
- A culture of partnership
- A Just culture
What Is the “Product” of a Safety Culture

- An observable degree of Effort towards improving safety
- Effort
  - How much energy?
  - For how long?
  - In the face of what obstacles?

Culture of Safety

Is State

Beliefs:
- Errors are rare
- Just give me a name
- Tell as little as you can
- Add more checks
- Thresholds for errors
- Fix as they happen

Future State

Beliefs:
- Errors are common
- Executives lead
- Tell the truth
- Look for latent causes
- Involve Board/Docs
- No error thresholds
- Thank the reporter
- Simplify the system
- Learn and prevent
Safety Culture Surveys

- Safety Attitude Questionnaire (SAQ)
- AHRQ Hospital Survey on Patient Safety Culture (HSOPS)
- VA Palo Alto/Stanford PSCI
- VA Patient Safety Questionnaire
- Flin/modified ORMAQ
- Itoh/Hospital Safety Culture Questionnaire
- Patient Safety Climate in Anesthesia
- Safety Climate Survey
- Culture of Safety Survey
- Children’s Hospital of Boston Trainee Supplement
- Allina Hospitals and Clinics
- Teamwork and Patient Safety Attitudes Questionnaire
- Safety Climate Scale

System Levels

Example

Microsystem

Mesosystem

Macrosystem

Source: Henrik, Bojestig, Jonkoping CC Sweden
Teamwork and its Component Parts

Dependent on Outstanding Leadership and Fair and Just Culture
Fact…

- Patient care is only as good as the care that is **delivered by frontline staff**.
  - The “front line staff” are in places where patients, families, and care teams meet

*Marjorie Godfrey Dartmouth College*

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Making the Connections

- Risk assessment
- Communicate
- Preventative action
- Measure impact
- Partnership
  - with patients and families
**Change vs. Improvement**

"Of all changes I’ve observed, only about 5% were improvements, the rest, at best, were illusions of progress.

W. Edwards Deming"

- We must become masters of improvement
- We must learn how to improve rapidly
- We must learn to discern the difference between improvement and illusions of progress

**Improving Patient Safety**

A Clear Aim, Measurement and Action!!
Questions?

Raise your hand

Use the Chat

The Model for Improvement

- **Testing** – Trying and adapting ideas and knowledge on small scale. Learning what works in your system.
- **Implementation** – Making the change a part of the day-to-day operation of the local system – a permanent change in how work is done
- **Spread** – Disseminating the change to additional units, sites, organizations who will implement independently

The Improvement Guide, API
Small Scale Tests of Change on:

- One bay/ward
- One day/shift
- One patient
- One nurse

1 3 5 ALL

Repeated Use of the PDSA Cycle

Sequential building of knowledge under a wide range of conditions

Changes That Result in Improvement
- Spread
- Implementation of Change
- Wide-Scale Tests of Change
- Follow-up Tests

Hunches Theories Ideas

Very Small Scale Test

DATA

1/26/2013
### PDSA Cycle No 1:
#### Worksheet for Testing Change

**Aim:**
*(Overall goal you would like to reach)* Every goal will require multiple smaller tests of change

<table>
<thead>
<tr>
<th>Describe your first (or next) test of change</th>
<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>List the tasks needed to set up this test of change</th>
<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Predict what will happen when the test is carried out</th>
<th>Measures to determine if prediction succeeds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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**Do:**

**Study:**
What happened?
What did you learn?
What surprised you?

**Act:**
What will you differently as a result of your test?
What will your next test be? When will it be?
Repeat the cycle

Test over a wide variety of conditions, different patients, different staff, days, nights, secondary care/primary care.
Measure, collect enough data to tell you if your test was a success.
Keep testing until the changes you are making result in improvements.
Data for Improvement

Using Data to understand progress toward the team’s aim

Using Data to answer the questions posed on in the plan for each PDSA cycle

Questions?

Raise your hand

Use the Chat
Summary

- Content and background to patient safety
- Essentials of teamwork
- Effective communication
- Measurement of adverse events
- Tools and techniques for the frontline staff
- Engaging patients and families in preventing harm

Work for Action Period

- Meet with your team and consider the following:
  - Who makes up your team?
  - Do actually you function as a team?
  - What is your collective purpose?
  - How do you prioritise patient safety issues?
- Independently ask 5 different members of your team what is their biggest safety concern
- Collectively agree on one specific safety aim/project for improving patient safety your unit
- Try testing “Safety Briefings” (see materials)
- If you already use them, share your learning
Volunteers?

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Questions?

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Raise your hand

Use the Chat
Expedition Communications

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- Pose questions, share resources, discuss barriers or successes

Next Session

Thursday, March 14, 1:00 PM – 2:00 PM ET
Session 2 – Essentials of Teamwork