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PEACE OF MIND | EXPERTISE | CHOICE | THE MEDPRO GROUP DIFFERENCE

Module 2: Part 2

Enterprise Risk Management

Culture of Safety

Objectives

Discuss the requirements for developing a culture of safety

Explore the tools used to measure and analyze culture of safety within the organization

Examine the benefits of implementing Just Culture® and TeamSTEPPS® throughout the organization

Culture of safety

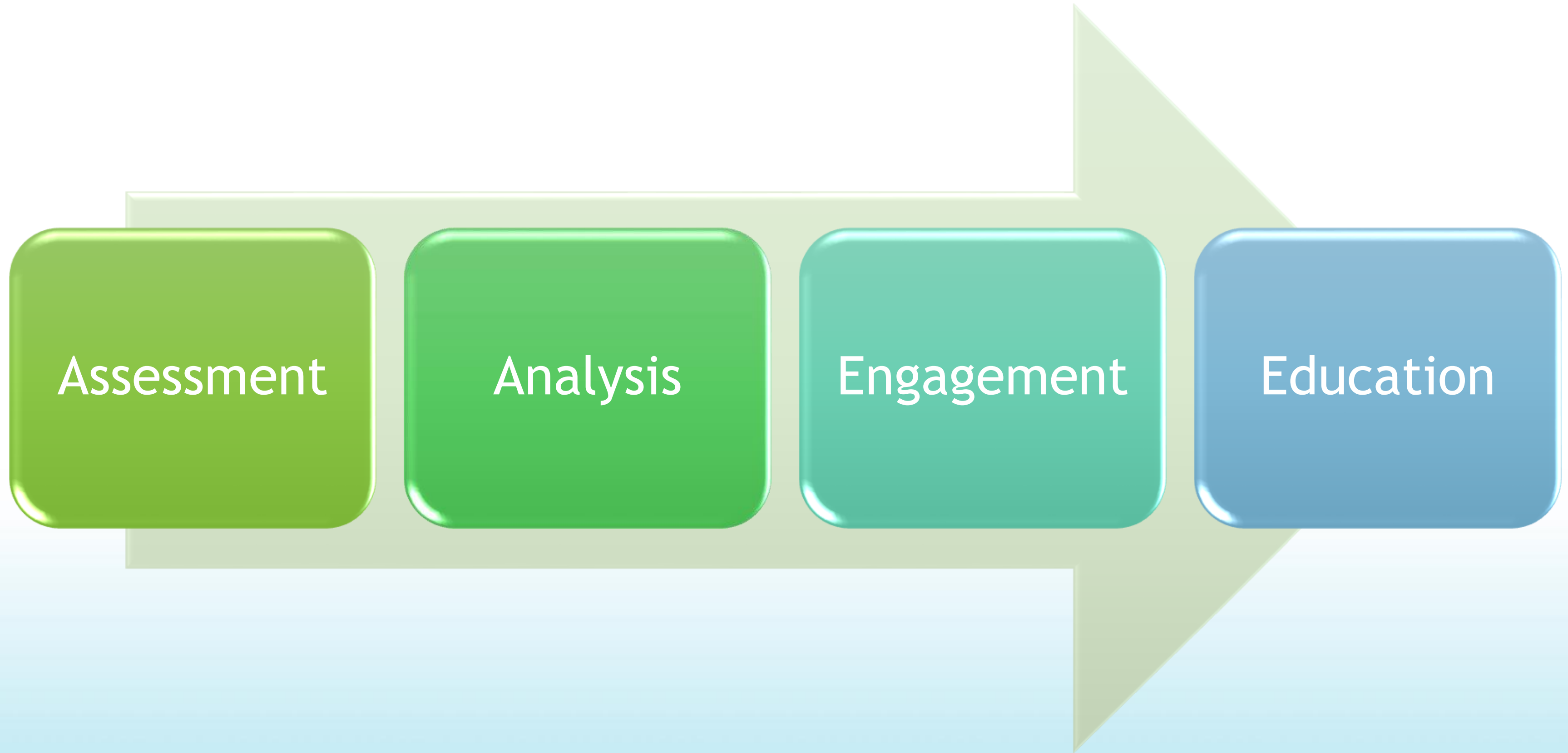
Source: Institute for Healthcare Improvement. *Leading a Culture of Safety: A Blueprint for Success*. Retrieved from http://www.npsf.org/page/cultureofsafety

Culture of safety

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

Lucian Leape, MD

Culture of safety development



Assessment

Patient satisfaction surveys

Event reporting data

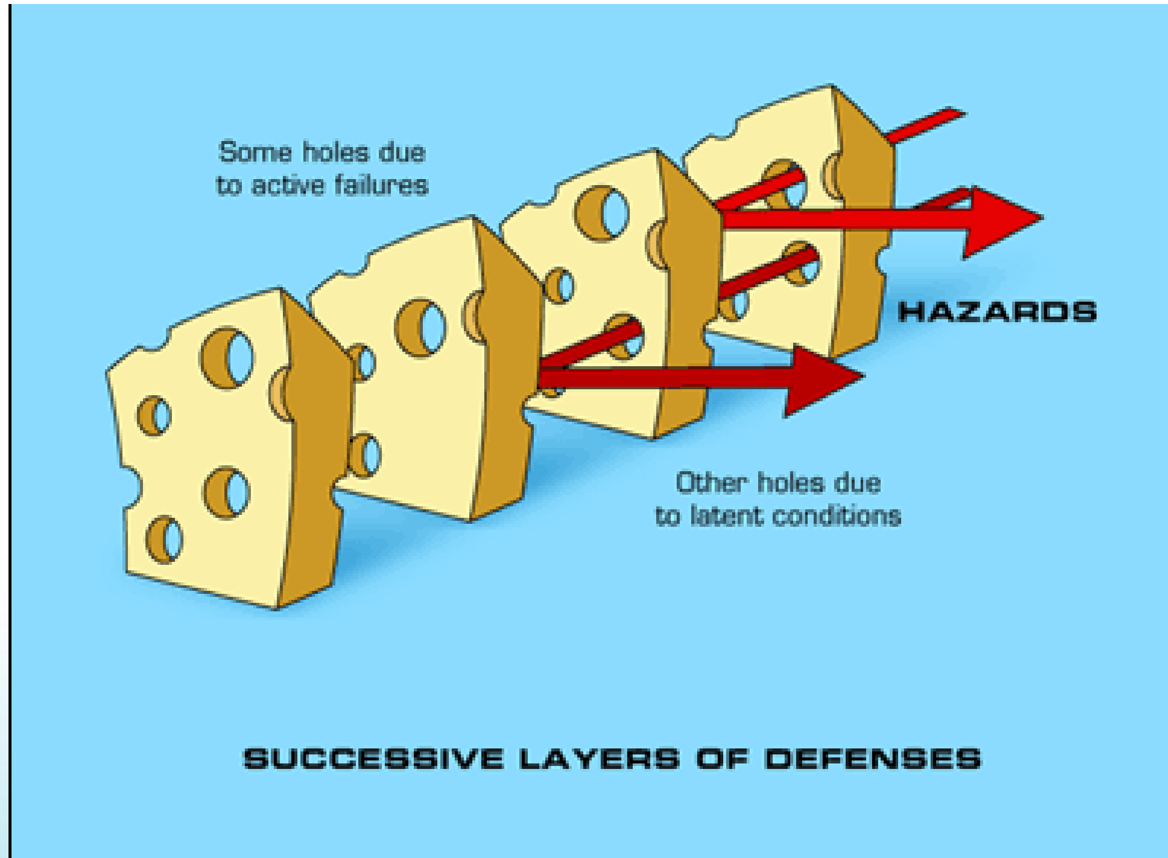
Claims data

Staff satisfaction and culture of safety surveys

Leadership culture of safety survey

360^0 organizational evaluation (internal and external)

Analysis



Source: Reason, J. (2000, March 18). Human error: Models and management. *BMJ*, *320*(7237):768-770.

Analysis

Active errors	Latent errors
• Sharp end • Point of contact	• Blunt end • Process or system design

Analysis

Human factors engineering

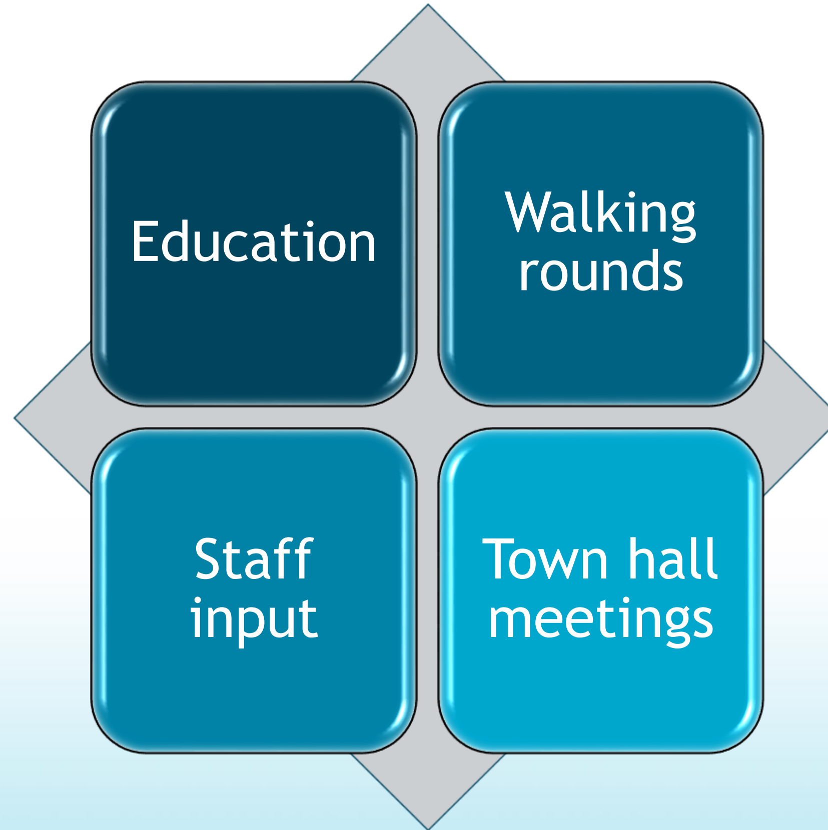
- Identify strengths and limitations
- Apply knowledge for system design

Components of engineering

- Usability testing
- Forcing functions
- Standardization
- Resiliency efforts

Source: Agency for Healthcare Research and Quality. (2017). Human factors engineering. Retrieved from https://psnet.ahrq.gov/primers/primer/20

Engagement



Education

Just Culture®

Principles

- Human error
- At-risk behavior
- Reckless behavior (negligence)

Source: Agency for Healthcare Research and Quality. (2017). Culture of safety. Retrieved from https://psnet.ahrq.gov/primers/primer/5/culture-of-safety

Education

Human error

- Fatigue
- Stress
- Preoccupation
- Chaos

Leadership response: Empathy

Education

- Omit steps
- Rewards versus consequences
- Normalization of deviance

Education

Reckless behavior

- Blatant disregard
- Intentional acts

Leadership response:
Disciplinary action

Education

AHRQ's TeamSTEPPS®

Education

TeamSTEPPS® core elements

- Communication
- Leadership
- Situation awareness
- Mutual support

Source: MedPro Group. Reducing risks through effective communication: AHRQ's TeamSTEPPs®. Retrieved from https://www.medpro.com/reducing-risk-od

Resources

- Agency for Healthcare Research and Quality. (n.d.) TeamSTEPPS. Retrieved from https://www.ahrq.gov/teamstepps/index.html
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Quiz question

Medical errors due to latent causes are typically the result of (select all responses that apply):

A. Improper equipment usage

B. Inappropriate clinician technique

C. Multiple procedures for one task (based on healthcare provider preference)

D. Negative work environment

Response

Latent causes are identified as being less apparent failures embedded within the layers of the healthcare organization. These would include:

C. Multiple procedures for one task (based on healthcare provider preference)

D. Negative work environment

Communication

Objectives

Discuss the importance of effective communication skills

Examine risk factors in handoff communications

Describe essential communication processes

Communication across the continuum of care

Interact with departments and committees

Share data analysis

Educate staff and governing body

Address patient and family

Manage claims

Coordinate public relations

Communication breakdowns

Patient and family complaints

Difficult patients and families

- Demanding
- Disruptive
- Noncompliant

Special needs patients

- Cultural
- Physical
- Limited English speaking patients
- Disabilities

Communication breakdowns

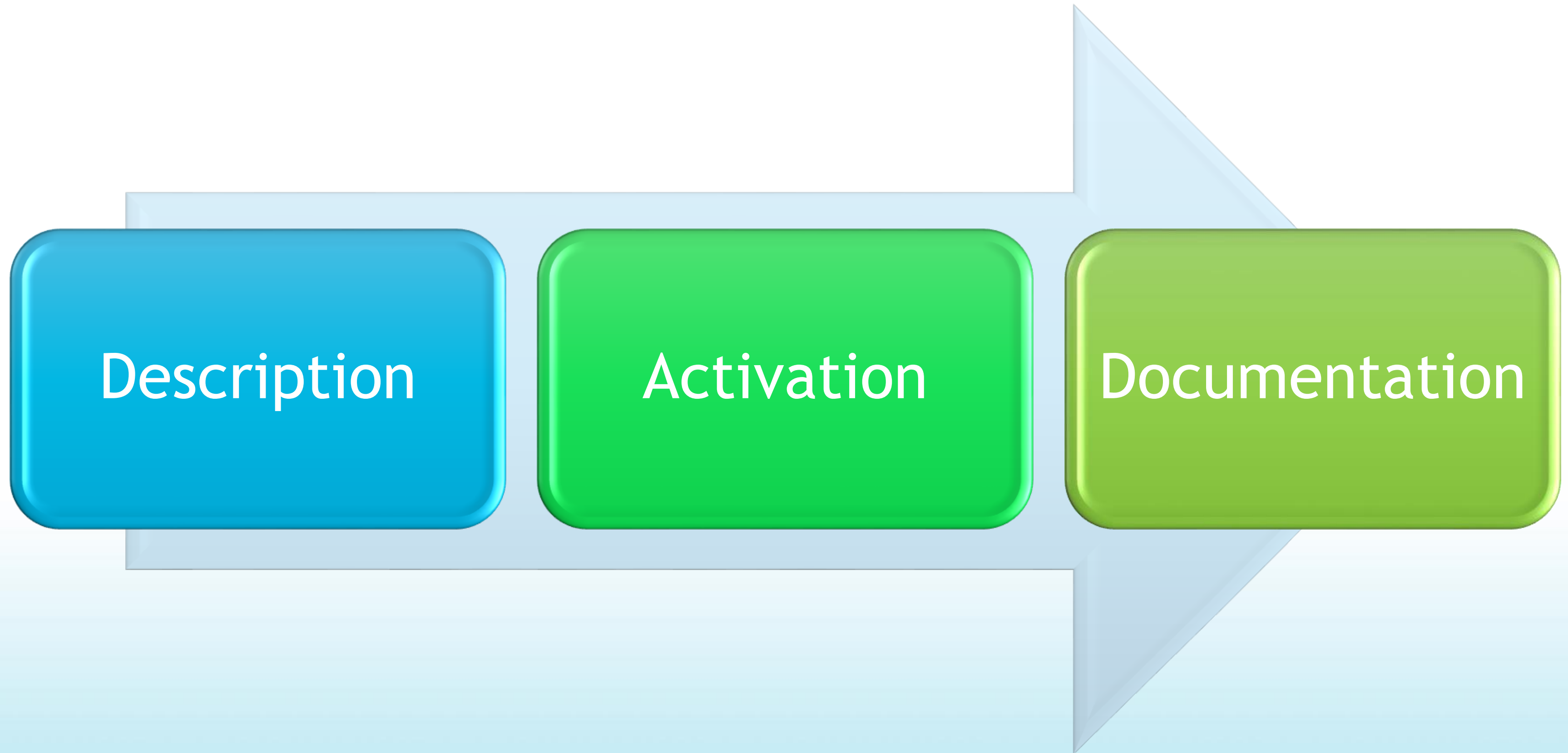
Internal communication

- Provider to provider
- Between staff and provider
- Tracking and follow-up
- Disruptive behavior

Handoffs

- Identify frequent handoff events
- Recognize communication barriers
- Provide training for staff and providers
- Assess the efficacy of handoff process
- Adjust process as needed

Chain of command



Discharge process

Multidisciplinary team approach

- Medication reconciliation
- Clear patient instructions
- Discharge checklist
- Timely discharge summary

Discharge planning

- Emergency Department discharges
- Diagnostic test results
- Primary care physician

Postdischarge follow-up

- Discharges against medical advice (AMA)

Disclosure and apology

Policy

- Process steps
  - Safety of patient
  - Determine who needs to be included in the disclosure
  - Timely disclosure to patient/family
  - Investigate
  - Meeting
  - Follow up
  - Who discloses
  - Document
- Healthcare provider and staff support

Resources

- Agency for Healthcare Research and Quality. (n.d.). Communication and Optimal Resolution (CANDOR) Toolkit. Retrieved from https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html
- Agency for Healthcare Research and Quality. (2017). Handoffs and signouts. Retrieved from https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts?q=handoffs+and+signouts
- Agency for Healthcare Research and Quality. (n.d.). Implement teamwork and communication. Retrieved from https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/modules/implement/index.html
- American Society for Healthcare Risk Management. (2010). Interpersonal communication skills. In R. Carroll (Ed.), *Risk Management Handbook for Health Care Organizations* (pp. 399-435). San Francisco, CA: Jossey-Bass Publishers.
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Resources

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- The Joint Commission. (2015). OSHA & worker safety: Guidelines for zero tolerance. *The Joint Commission Environment of Care News*, *18*(8). Retrieved from https://www.jcrinc.com/assets/1/7/August_2015.pdf

Quiz question

What are some examples of active and latent errors that can result in communication failures?

Response

- Communication failures resulting in active and latent errors include:
  - Active
    - Not documenting patient care information, whether late entry or not at all
    - Not providing a thorough handoff regarding the patient’s status or care
    - Documenting the wrong information in the patient’s chart
  - Latent
    - Not being informed of a patient’s arrival on the unit by a coworker who refuses to speak to you
    - Not having an alert or warning system in place for same-name patients
    - Using hybrid documentation systems throughout the organization

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Complaints and Grievances

Objectives

Define complaint and grievance

Discuss facility and staff roles

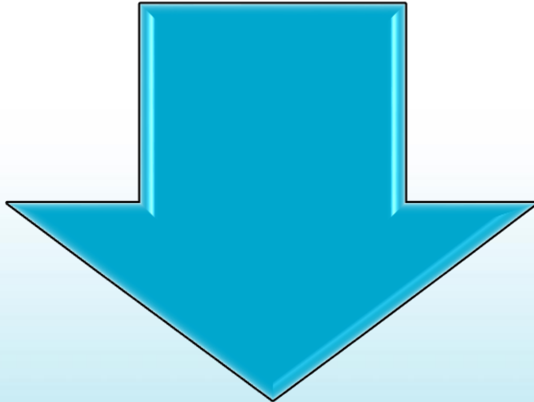
Identify nonpatient sources of complaints and grievances

Examine strategies for mitigation

Complaint or grievance

What is a complaint?

- Prompt resolution
- Leadership and staff involvement



What is a grievance?

- Formal or informal, written or verbal
  - Unresolved complaint
  - Allegations of abuse or neglect
  - Centers for Medicaid and Medicare Services (CMS) compliance issues
- Requires written response

Facility responsibilities

Policy and procedure

Grievance committee

Patient rights

Grievance investigation

Ongoing communication

Goal of patient satisfaction

Continuous organizational improvement

Response to complaints

Staff and physician education

- Active listening
- Management of patient expectations

Staff response to patient complaints

Other complaint sources

- Accrediting organizations
- Private insurance
- HIPAA/OCR (Office of Civil Rights)
- State Attorney General Offices
- Compliance concerns
- Departments of Health and Professional Licensing Boards

HIPAA: Health Insurance Portability and Accountability Act

Ten most common complaints

1. Sleep deprivation resulting from clinical interventions
2. Noisy nurses station at night
3. Lost personal belongings
4. Staff not knocking before entering the room
5. Staff not keeping whiteboards updated
6. Unclear communication/staff not updating family of condition changes
7. Messy/dirty rooms
8. Staff not including the patient in care decisions
9. No orientation to room and hospital
10. Lack of staff professionalism, especially on break

Proactive strategies to minimize complaints

- Solicit feedback from patients
- Promote the role of the patient advocate
- Provide patients with a complaint brochure
- Manage patient expectations
- Provide service recovery
- Include in Ongoing Professional Practice Evaluation (OPPE) program

Resources

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Quiz question

How can complaints and grievances be used in the organization's performance improvement program?

Response

By tracking and trending complaints and grievances, an organization can examine various areas of concern. For example, complaints received about the admission process can provide an excellent opportunity for conducting a failure mode effects and criticality analysis. This will enable a better understanding of the current process regarding what is working and what are some barriers impeding the process. For challenges surrounding admission, do the complaints relate to lengthy wait times to get a bed, inadequate staffing, information technology issues, delays in discharges, etc.?

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