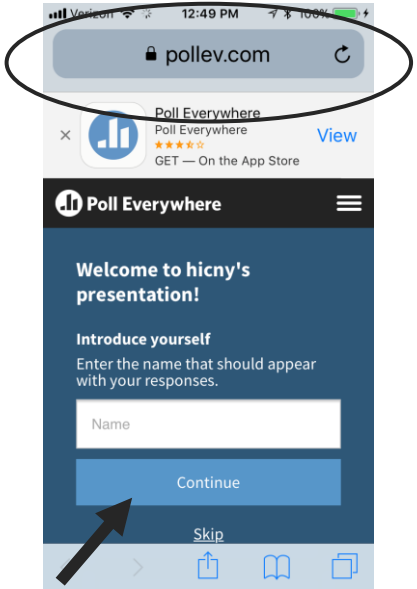
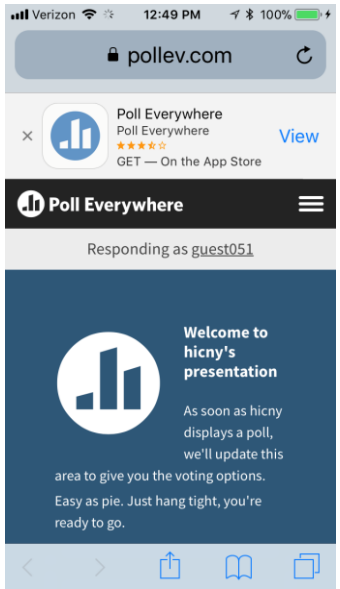
Participating with Poll Everywhere

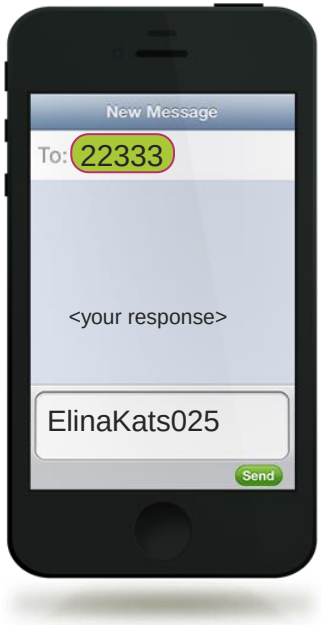
How to vote via the web or text messaging

From any browser go to Pollev.com/HICNY





Use a text message



In one word describe the last 3 years for you.

CREATING A CULTURE OF SAFETY

David L. Feldman, MD MBA CPE FAAPL FACS

GREATER NEW YORK HOSPITAL ASSOCIATION & UNITED HOSPITAL FUND

CLINICAL QUALITY FELLOWSHIP PROGRAM

Disclosure of Conflict(s) of Interest

- David L Feldman, MD reports no financial interest/relationships.

What does the public see?

Agenda

- Background - Respect
- Reliable teams
  - TeamSTEPPS
  - Time-outs & Checklists
  - Advanced teamwork tools
- Reliable processes
  - System Design
  - Human factors
- Just Culture
  - Reporting and accountability

Patient Safety & Respect

"...the key success factors in a safety effort are teamwork and respect, two basic ideas that are too often lacking in medicine. People have to be trained to work in teams and to respect others on the team."

Interview with Lucian Leape, MD. *Journal of Healthcare Management*. Volume 53, Number 2. March/April 2008.

When poll is active, respond at **pollev.com/elinakats025**

Text **ELINAKATS025** to **22333** once to join

I have been treated disrespectfully by someone at work in the last week.

Yes

No

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Text **ELINAKATS025** to **22333** once to join

I have seen others being treated disrespectfully at work in the last week.

Yes

No

Prior Results

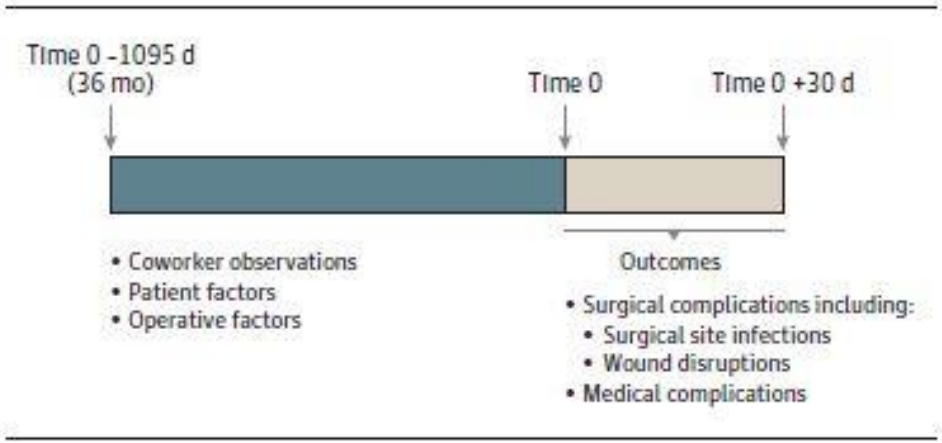
"I have been treated disrespectfully"

	CQFP Fellows 2018 (n=24)	CQFP Fellows 2019 (n=28)	CQFP Fellows 2022 (n=25)	AHA Webinar 4-19 (n=414)	AHA Conf 6-19 (n=33)	MSIII 9-22 (n=67)	FMA 2-23 (n=134)
Yes	67%	64%	40%	37%	30%	13%	22%
No	33%	36%	60%	63%	70%	87%	78%

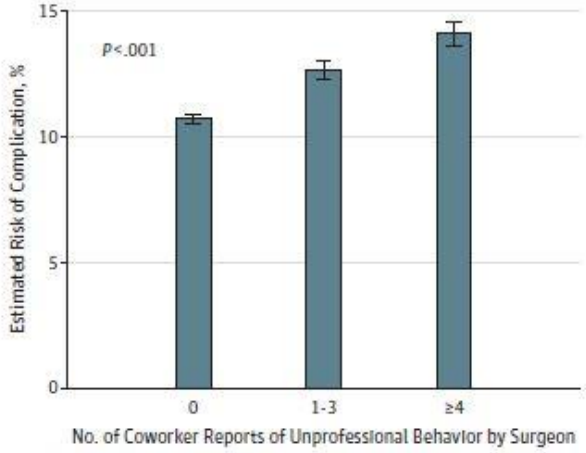
"I've seen others being treated disrespectfully"

	CQFP Fellows 2018 (n=27)	CQFP Fellows 2019 (n=27)	CQFP Fellows 2022 (n=25)	AHA Webinar 4-19 (n=411)	AHA Conf 6-19 (n=36)	MSIII 9-22 (n=77)	FMA 2-23 (n=157)
Yes	85%	78%	96%	66%	67%	57%	31%
No	15%	22%	4%	34%	33%	43%	69%

Co-Worker Complaints & Outcomes



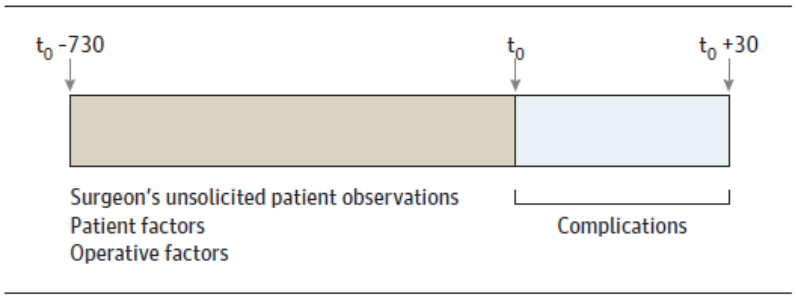
CORS & NSQIP data from Stanford and Vanderbilt



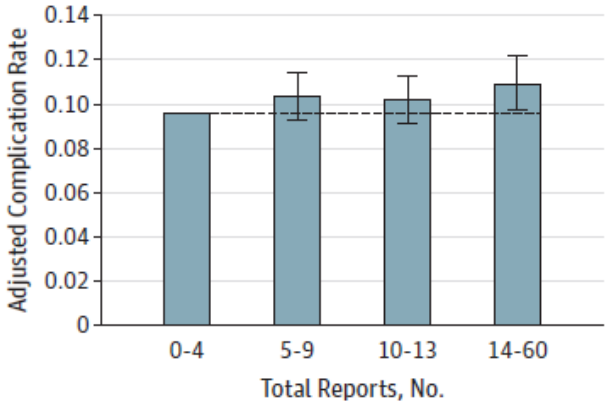
"...nurse [who] reports, "I asked for the procedure time out. Dr X said, 'Look, we're all on the same page here. Let's get going without all this time out nonsense,'"

Cooper, *JAMA Surgery*, 2019.

Patient Complaints & Outcomes



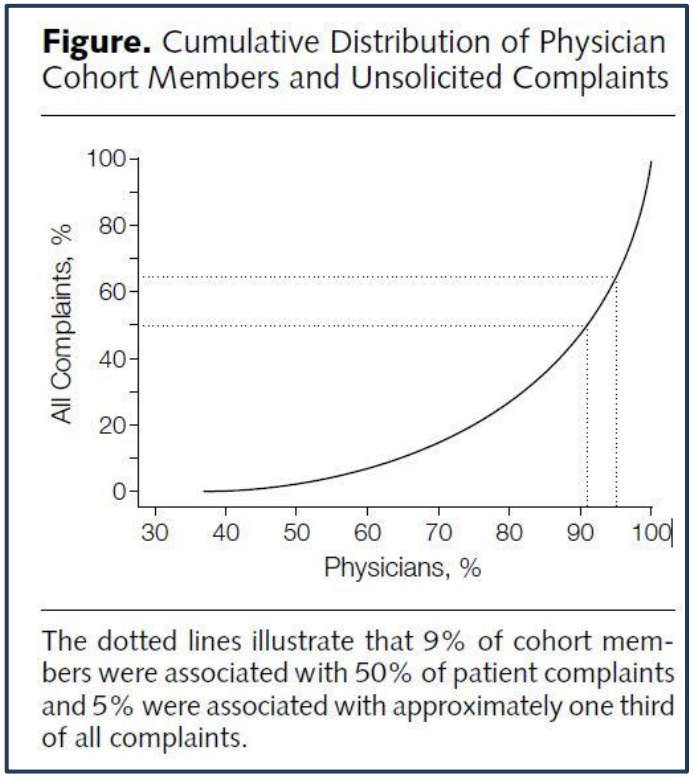
PARS & NSQIP data from Emory, Stanford, UCLA, UNC, UPenn, Wake, Vanderbilt



"I asked Dr Y how long he thought the operation would take. He said, 'Look, your wife will die without this procedure. If you want to ask questions instead of allowing me to do my job, I can just go home and not do it.'"

Cooper, *JAMA Surgery*, 2017, 522-529.

Patient Complaints & Malpractice Risk



645 general and specialist physicians.
January 1992 - March 1998.
2,546 physician-years of care.

Patient Complaints (adjusted for clinical activity) related to:

- Risk management file openings
- File openings with expenditures
- **Lawsuits**

Hickson, *JAMA*, 2002.

Range of Disrespectful Behavior

- Disruptive behavior
- Humiliating, demeaning treatment of nurses, residents, and students
- Passive-aggressive behavior
- Passive disrespect
- Dismissive treatment of patients
- Systemic disrespect

Leape, *Acad Med*, 2012, 845-852.

Effective Disrespectful Behavior Policies

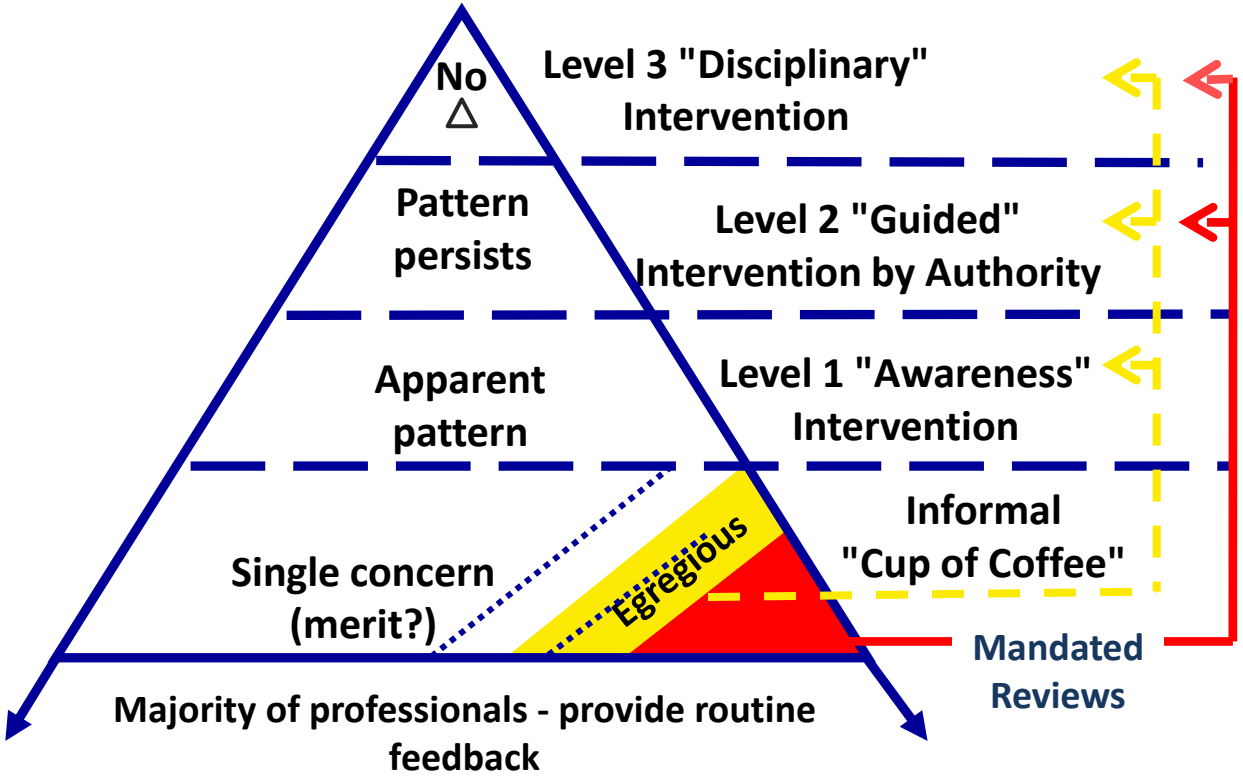
- Fairness
- Consistency
- Graded response
- Restorative process
- Surveillance mechanisms

Leape, *Acad Med*, 2012, 853-858.

Vanderbilt University Medical Center
Center for Patient and Professional Advocacy

- Professional Conduct Policy
- Training for faculty in
  - Commitment to *Credo behaviors*
  - Feedback to students & residents
  - Behavior policy
- Patient Advocacy Reporting System (PARS^{SM})
- Co-Worker Observation Reporting System^{SM} (CORS^{SM})

Promoting Professionalism Pyramid



Webb et al. *Jt Comm Jnl Qual Saf* 2016;149-161

Maimonides Medical Center

Code of Mutual Respect

- Clear expectations of respectful behavior that applies equally to everyone
- Recognition of and mechanisms to address systems issues that cause frustrations
- Investigations conducted by unbiased peers from other departments
- Progressive discipline that is similar in concept for physicians and other employees

- Skills training program
- Mediated conversations
- Respect survey

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Which elements of an effective disruptive behavior policy does your institution have? (Choose all that apply)

- Fairness
- Consistency
- Graded response
- Restorative process
- Surveillance Mechanisms
- None of the above

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  - **Time-outs & Checklists**
  - **Advanced teamwork tools**
- Reliable processes
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  - Human factors
- Just Culture
  - Reporting and accountability

Teamwork is all around us










What is a team?

- Two or more people who achieve a mutual goal through *interdependent* and *adaptive* actions
- Not a “group” which achieves its goal through *independent, individual* contributions

An expert team!

Shared Mental Model

An effective team should have

The same people working together for each task

Team members with similar backgrounds and training

A chance to practice before the "real thing"

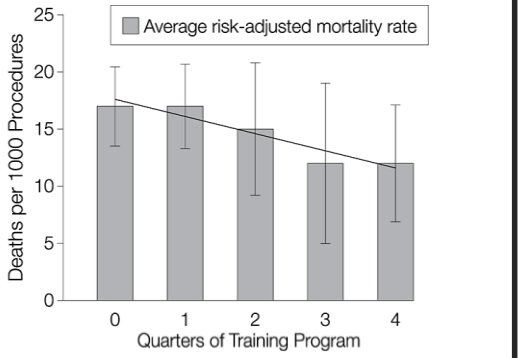
Members that hold a shared mental model

TeamSTEPPS®

Team Strategies & Tools to Enhance Performance & Patient Safety

"Initiative based on evidence derived from team performance…leveraging more than 25 years of research in military, aviation, nuclear power, business and industry…to acquire team competencies"

TeamSTEPPS®



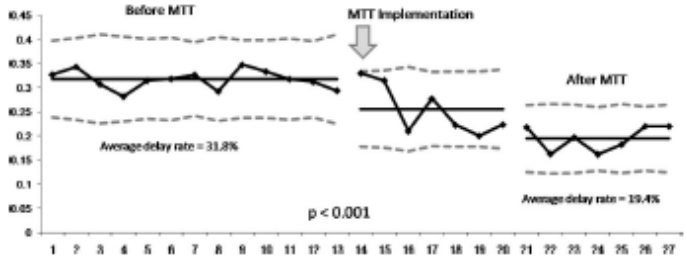
Neily,J. et al. *JAMA 2017*

Table 3. Operating Room Efficiency Data.

	Before TeamSTEPPS	With TeamSTEPPS	*P* Value
Mean anesthesia start to in-room time (minutes)	10.97	11.30	.200
Mean in-room to turnover-to-surgeon time (minutes)	14.45	13.75	.017[a]
Mean turnover-to-surgeon to surgical start time (minutes)	16.29	15.19	.004[a]
Mean surgical time (minutes)	83.45	72.23	<.001[a]
Mean case time (minutes)	125.16	112.47	<.001[a]
On-time first-start rate	48.9%	69.8%	<.001[a]
Mean late interval for first-start cases (minutes)	12.46	14.54	.212
Mean turnover time (minutes)	41.48	40.49	.193

Abbreviation: TeamSTEPPS, Team Strategies and Tools to Enhance Performance and Patient Safety.
[a]Statistically significant.

Weld LR, *Am J Med Qual* 2016, 408-414

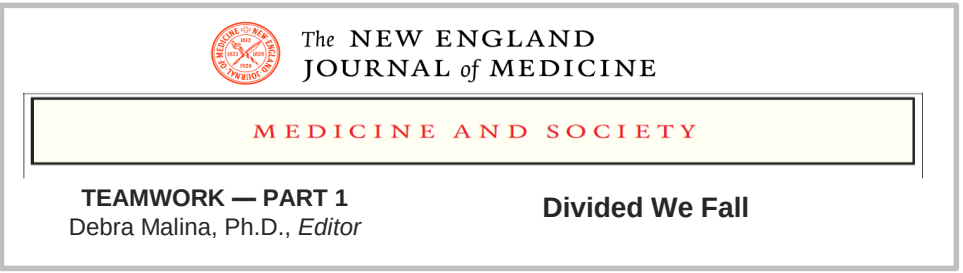


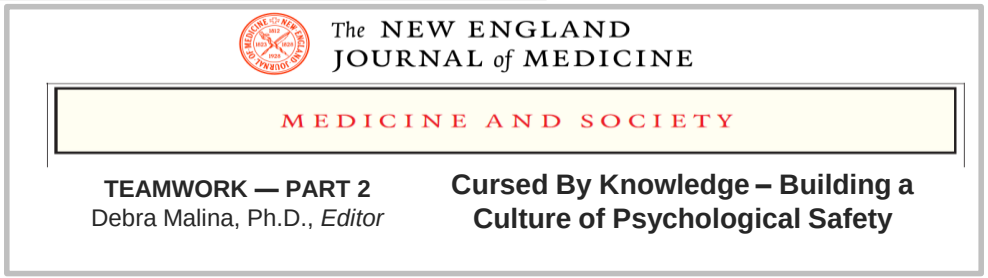
Wolf,FA et al. *Annals of Surg, 2010*

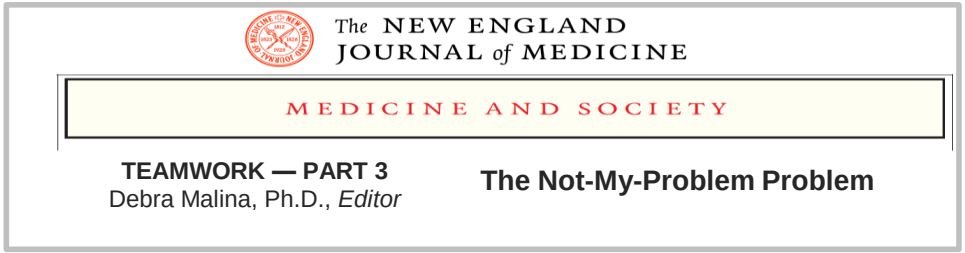
	Pre	Post	% change
Deliveries	14,271	19,380	
Adverse Outcome Index	5.9%	4.6%	-23%
Weighted Adverse Outcome Score	1.15	.782	-33.2%
Severity Index	19.59	17	-13.2%

Pratt, S. et al. *Jt Comm Jnl Saf & Qual 2007*

Teamwork – Still a Problem



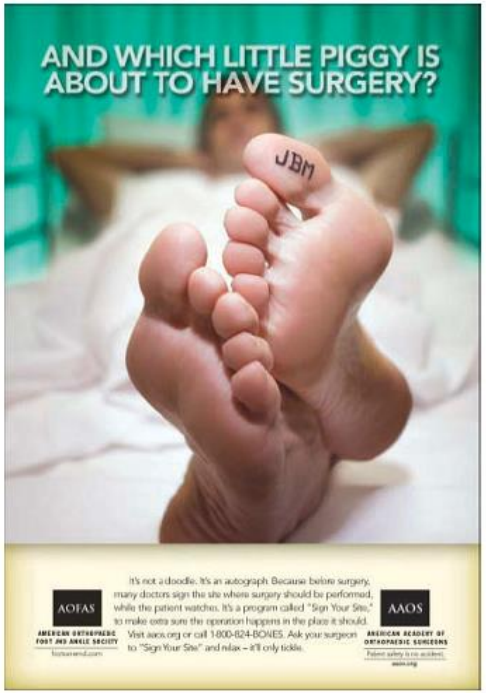




Rosenbaum, *NEJM*, 2019.

The Joint Commission Universal Protocol

- Pre-procedure verification process
  - A conversation between Attending Anesthesiologist and Attending Surgeon
- Site Marking
  - NYS – surgeon marking site, must be present for time-out and perform procedure
- Time-Out
  - NYS – immediately prior to incision
  - Best practice requires:
    - Attending Surgeon
    - Attending Anesthesiologist
    - Circulating RN



WHO Surgical Checklist - 2009

"Safe Surgery Saves Lives"

World Health Organization

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ▸▸▸▸▸▸▸▸▸ Before skin incision ▸▸▸▸▸▸▸▸▸▸▸▸▸ Before patient leaves operating room

SIGN IN

- ☐ **PATIENT HAS CONFIRMED**
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ **SITE MARKED/NOT APPLICABLE**
- ☐ **ANAESTHESIA SAFETY CHECK COMPLETED**
- ☐ **PULSE OXIMETER ON PATIENT AND FUNCTIONING**

DOES PATIENT HAVE A:

KNOWN ALLERGY?
- ☐ NO
- ☐ YES

DIFFICULT AIRWAY/ASPIRATION RISK?
- ☐ NO
- ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
- ☐ NO
- ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ **CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE**
- ☐ **SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM**
  - PATIENT
  - SITE
  - PROCEDURE

ANTICIPATED CRITICAL EVENTS

- ☐ **SURGEON REVIEWS:** WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ **ANAESTHESIA TEAM REVIEWS:** ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ **NURSING TEAM REVIEWS:** HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
- ☐ YES
- ☐ NOT APPLICABLE

IS ESSENTIAL IMAGING DISPLAYED?
- ☐ YES
- ☐ NOT APPLICABLE

SIGN OUT

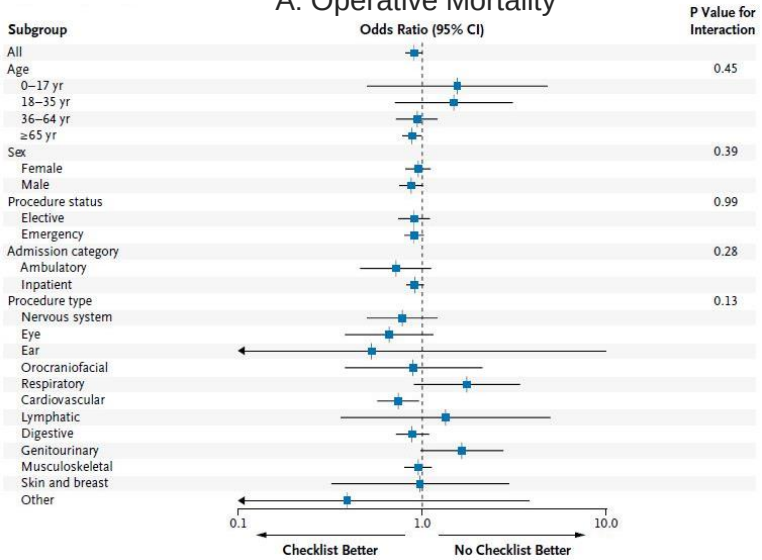
NURSE VERBALLY CONFIRMS WITH THE TEAM:

- ☐ **THE NAME OF THE PROCEDURE RECORDED**
- ☐ **THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT** (OR NOT APPLICABLE)
- ☐ **HOW THE SPECIMEN IS LABELLED** (INCLUDING PATIENT NAME)
- ☐ **WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED**
- ☐ **SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT**

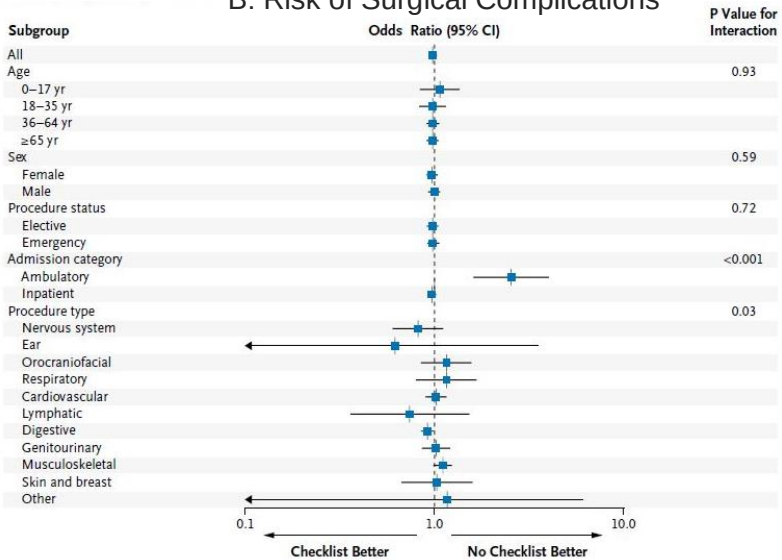
THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

Checklists in a Vacuum

A: Operative Mortality



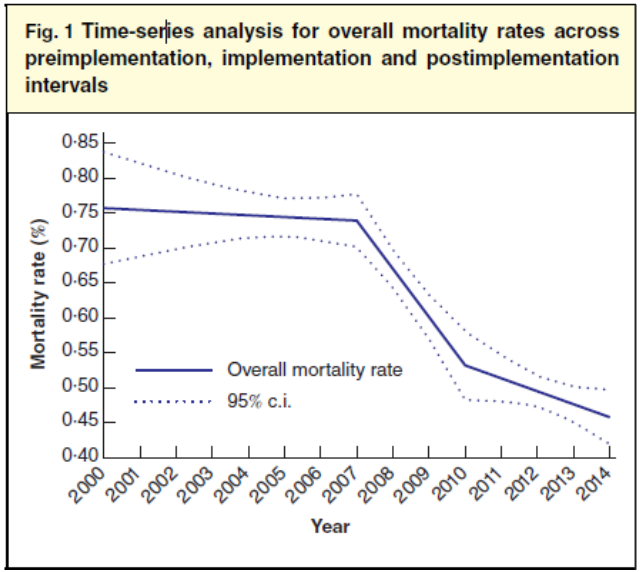
B: Risk of Surgical Complications

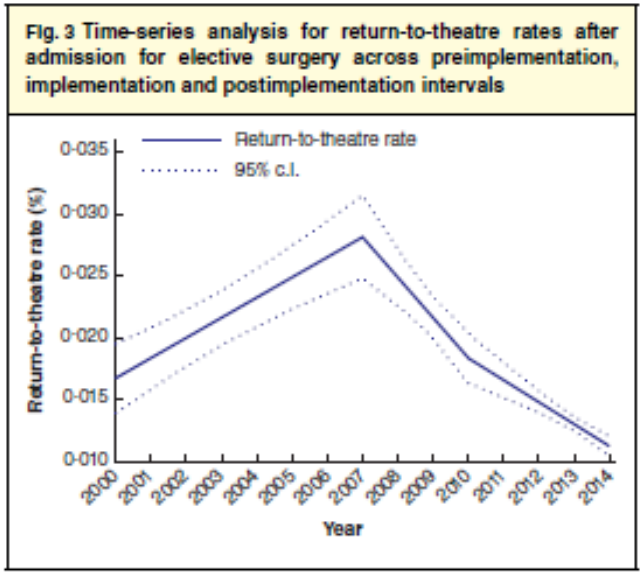


"Ninety-two of the 101 study hospitals provided copies of their checklist; of these, 90% used an unmodified World Health Organization (WHO) or Canadian Patient Safety Institute checklist. Educational materials were made available to hospitals, but no team training or other support was provided."

Urbach, *NEJM* 2014, 1029-1038. Leape, *NEJM* 2014, 1063-1064.

Checklists as Part of a Safety Program





Ramsay, *Br J Surg* 2019.

"The surgical checklist was not a stand-alone intervention. This study provides further evidence that the success of checklist implementation is more pronounced when it is supported by a cohesive and wider approach to patient safety."

Telling is Not Training

Training requires four steps:

- Provide information
- Demonstrate how to apply the information
- Provide the learner an opportunity to practice
- Provide feedback relative to a standard

From: "*Telling is not training*"
Capt. Stephen W. Harden

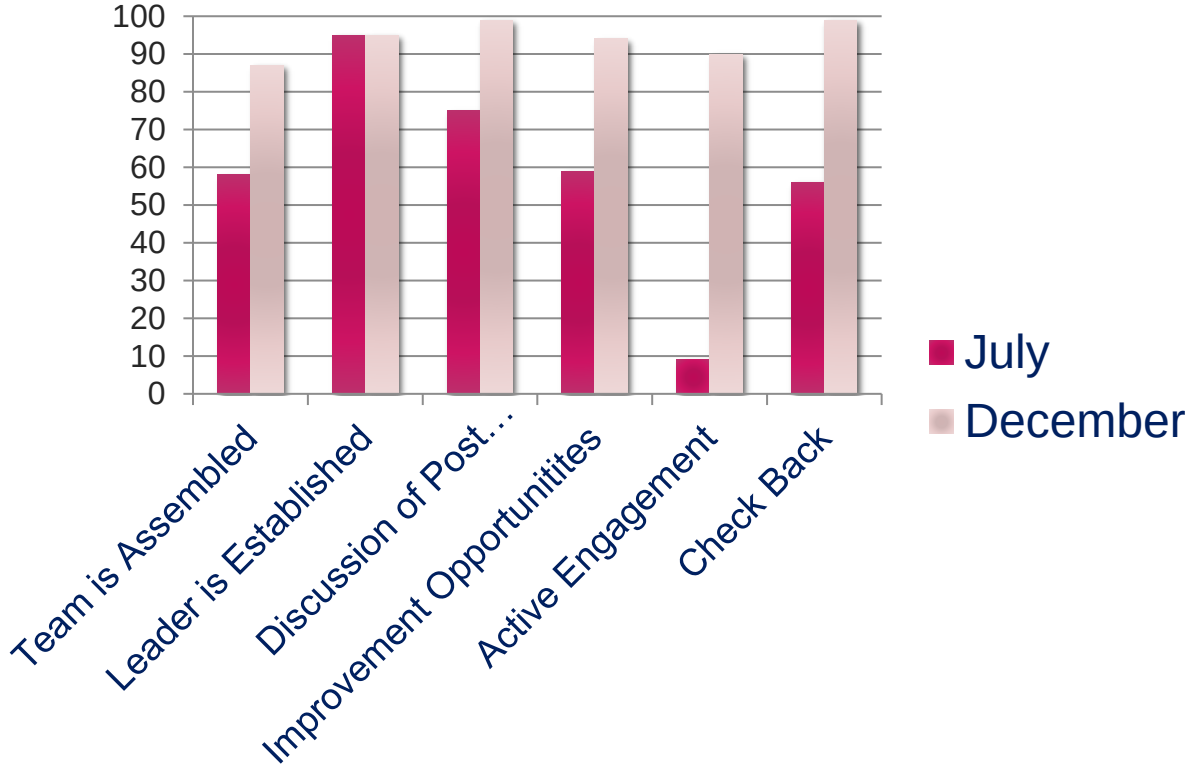
Time Out/Sign Out Observation

- Customized observation tool
- Developed by 25-30 surgeons, anesthesiologists and nurses
- Time Out & Sign Out as proxies for teamwork events
- Database collection of observations - Checkbox
- Training of observers/ Install video cams
- Feedback to surgical teams
- Video v live observation

	Total #	Live	Video	P value
Time Out	1410	325	1085	
Compliance		30.5%	15.3%	<.001
Sign Out	1398	166	1232	
Compliance		28.3%	21.8%	.075

Bui et al, Surgery, 2018

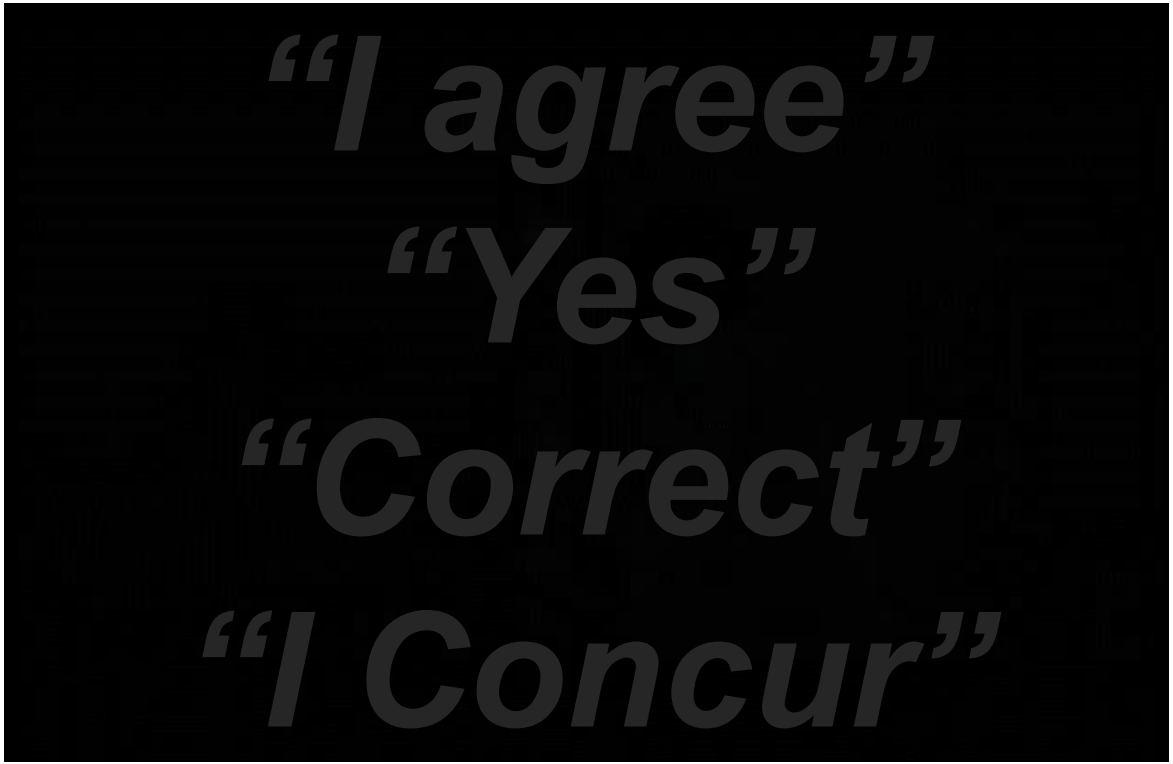
Time Out Audit Performance



Rhee et al, *Am J Med Qual*, 2017

In ONE word, describe time-outs at your institution.

“I concur.”



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  - **Human factors**
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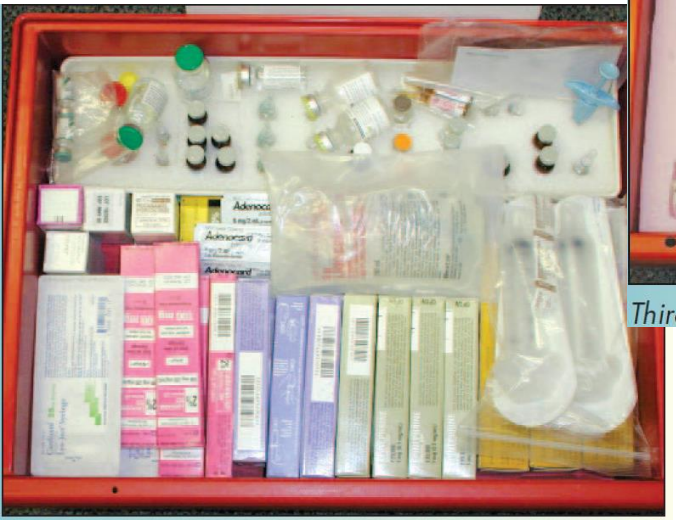
Human Factors All Around Us…

Where do I go…?

Visual Controls - Close to Home

Visual Controls in the Code Cart



Baseline drawer

Third iteration

Final product

McLaughlin *Am J Nurs*, 2003

Visual Controls in the OR

June 28, 2004

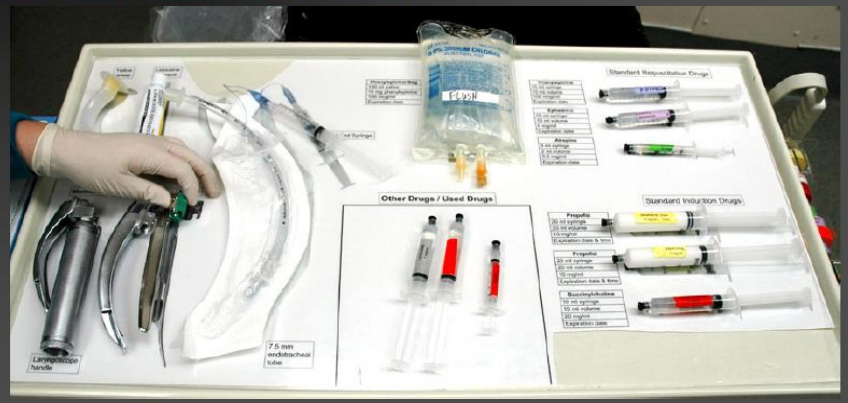
Visual Control for Safety

TEAM MEDICINE VIRGINIA MASON

5S Anesthesia “Shadow Board” - Before

Visual Control for Safety

TEAM MEDICINE VIRGINIA MASON



5S Anesthesia Shadow Board - After

Preventing Retained Surgical Items

Bar Coding

Radiofrequency

Preventing Retained Surgical Items

- Prevention - Counting, Teamwork, Radiography, New technology
- Risk Reduction Strategies to Decrease the Incidence of RSI
  - 997,237 Operative Procedures
  - TeamSTEPPS training and RF technology interventions
  - RSI decreased - 11.66 to 5.80 events per 100,000 operations
  - RSI involving RF detectable items decreased - 5.21 to 1.35 events per 100,000 operations
  - Malpractice claims related to sponges and lap pads decreased - 1.6/year to .67/year

Feldman, *Mt Sinai J Med,* 2011.
Kaplan, *JACS*, 2022.

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  - **Reporting and accountability**

What is a just culture?

Peer review done fairly

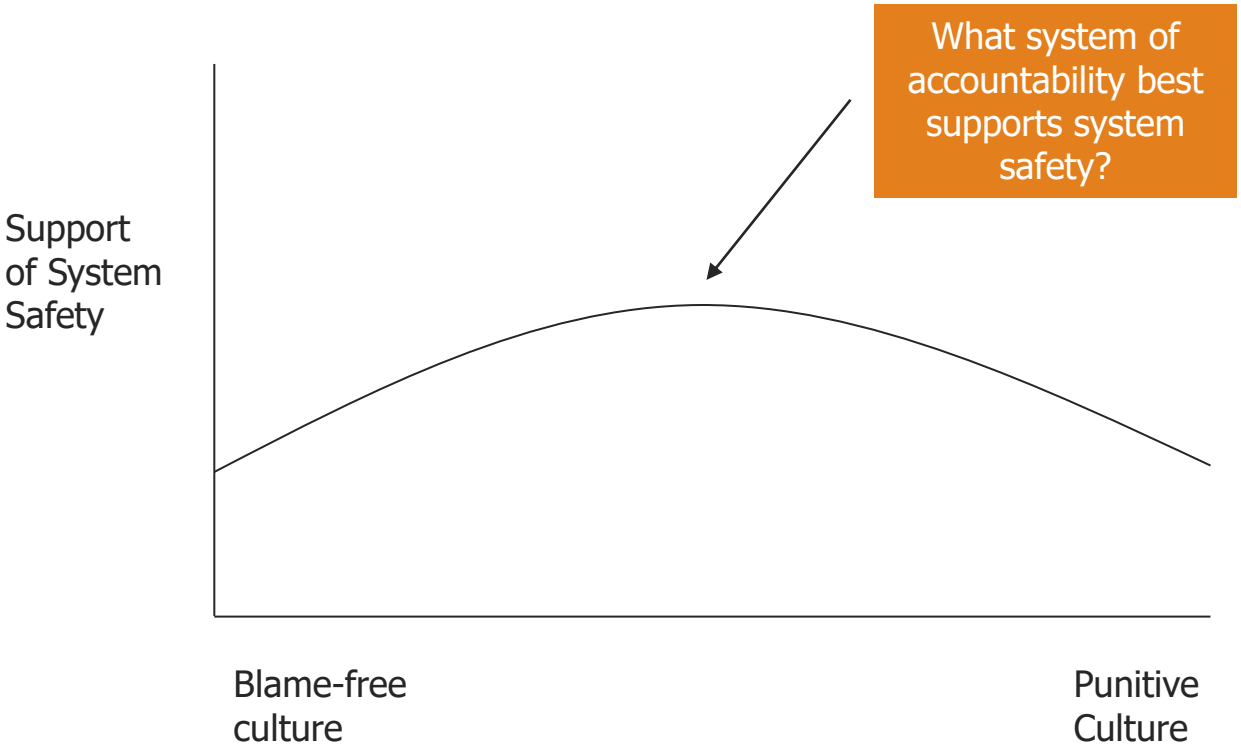
Balancing no-blame and being punitive

Leaders don't point fingers

Focus on systems

Clinicians get what they deserve

What is a Just Culture?



Accountability for our behaviors

Human Error	***At-Risk Behavior***	***Reckless Behavior***
Manage through changes in: ✶Processes ✶Procedures ✶Training ✶Design ✶Environment	Manage through: ✶ Removing incentives ✶ Creating incentive for healthy behavior ✶ Increasing situational awareness	Manage through: ✶Remedial action ✶Disciplinary action
Console	Coach	Punish

Accountability of Our Behaviors

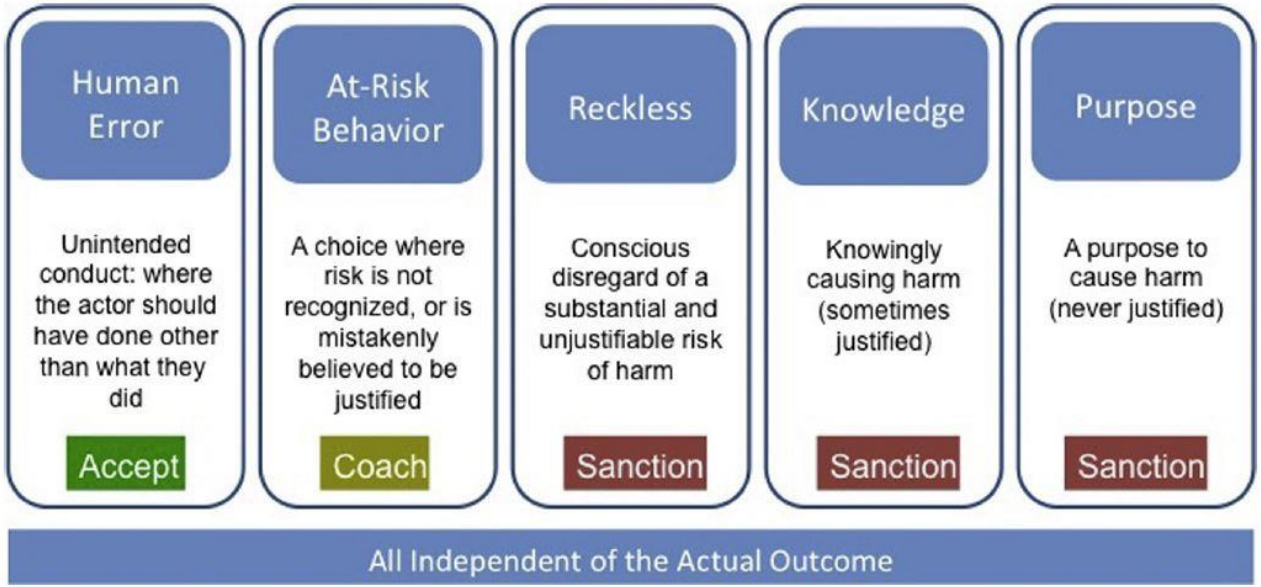
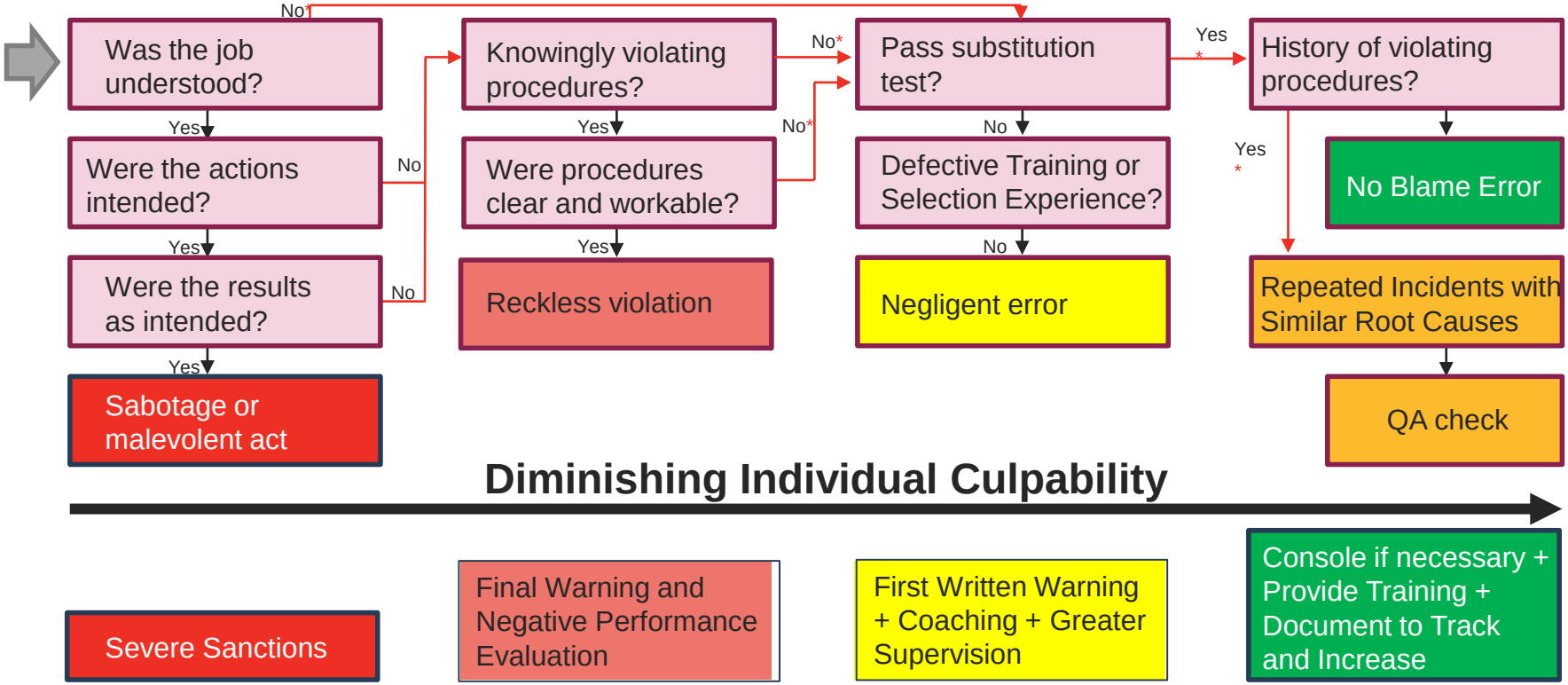


Fig. 3. Just response to the 5 behaviors. (Copyright Outcome Engenuity 2017.)

Focus on choices NOT outcome

Marx *OB-GYN Clin NA,* 2019.

Just Culture "Decision Tree"



*Indicates a Systems Error: Corrective and Preventive Action is Required

Adapted from The Just Culture Community (2016). David, *J Pat Saf*, 2019

Why a Just Culture?

- Punishing human error (and even at-risk behavior) creates a culture of fear
- In a culture of safety reporting of all events, whether near misses or real misses, is encouraged
- Excellence not perfection
- Error is inevitable, error management is the aim

Scenario

A surgery resident accidently contaminates an instrument in the OR. No one notices. The instrument is critical to the procedure and the resident knows if the instrument has to be re-sterilized it will delay the procedure by at least 20 minutes to either re-sterilize or call for a replacement. Knowing the attending surgeon has a history of being abusive to residents, the resident says nothing.

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Do you think this was:

Human Error - Console

At-Risk Behavior - Coach

Reckless Behavior - Censure

Just Culture

“Tragedy followed by injustice, once again.”

7 Strategies for Creating Psychological Safety

- Reduce the rate of harm
- Revise your disciplinary policies
- Conduct and share a complete root cause analysis
- Take organizational ownership of the event
- Reject no harm, no foul
- Express a fierce intolerance for reckless behavior
- Get professional board, regulators, and the press on your side

David Marx. Thoughts in the Aftermath of the Criminal Prosecutions of RaDonda Vaught and Kim Potter. *LinkedIn* 4-5-22

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Leadership in Patient Safety…

Comments and Questions?