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A Comprehensive Framework for Patient Safety

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Disclosure: I am a Principal in a company called Pascal Metrics Inc. that develops and implements safety metrics. We will be discussing this topic in general and will reference many options about safety metrics, including those produced by Pascal. We will disclose the commercial interests we have, and present a balanced view of the topic.

A Framework for a System of Safety Objectives

1. Link safety to organizational strategy and resources
2. Define a culture of safety
3. Apply improvement methods through applied human factors and reliability science
4. Differentiate continuous learning systems (at organization and unit levels)
5. Describe patient safety governance
6. Link patient safety and patient centeredness

A Safety Framework – 8 components

Personal Habits

1. Risk Factors
2. Exercise
3. Nutrition
4. Health Literacy
5. Etc

Physical Exam

1. Cardiovascular
2. Pulmonary
3. Gastrointestinal
4. Musculoskeletal
5. Etc

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A Safety Framework – 8 components

Culture of Safety

1. Leaders
   who facilitate and mentor teamwork, improvement, respect and psychological safety
2. Teams
   who know the game plan and agree upon specific behaviors
3. Communication
   where transmission and reception of information is one and the same
4. Accountability
   that supports psychological safety because employees believe that they'll be treated fairly

Learning System

1. A Continuous Learning Process
   that generates reliable care by applying best evidence and minimizing variation
2. Reliable Care Processes
   continuously, owned by frontline providers
3. Applies Formal Improvement Methods and Measurement
   to generate quality and mitigate and eliminate defects
4. Transparency
   where the learning efforts are known to all and discussed as a daily part of work

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Leadership

- Guardians of the Learning System
- Ensure Psychological Safety
  - Approachable
- Competent

Psychological Safety

- Image Protection
  - Stupid
    - Don’t ask questions
  - Incompetent
    - Don’t request feedback
  - Negative
    - Don’t criticize
  - Disruptive
    - Don’t make suggestions

Attribution: Amy Edmondson

Teamwork

- Plan forward
- Reflect back
- Resolve conflict
  - Brief
  - Debrief
  - Critical language

Briefing

- Goal and Game Plan
- Psychological Safety
- Norms of Conduct
  - Attitudes
  - Behaviors
- Expectations of Excellence

Debrief

- What worked well?
- What didn't?
- What should we differently next time?

Communication

- Communicate clearly
  - SBAR
  - Closed loop communication

Just Culture

- You can’t be malicious
- You can’t have you sensorium impaired
- You can’t be reckless

- Would 3 others with similar skills in the similar situation do the same?

- Do you have a history of unsafe acts?

Attribution: James Reason and David Marx

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Continuous Learning System

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An Improvement Method

- Driver Diagrams
  - Set Aims
  - Link Strategy to Tactics (Objectives to Action)
- PDSAs
  - What are we trying to accomplish?
  - What change are we making?
  - How will we know the change is an improvement?
- Deployment plan
  - Testing, Implementation, Spread

Reference Material

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TO ACHIEVE SAFE AND RELIABLE CARE:

PATIENT CENTEREDNESS

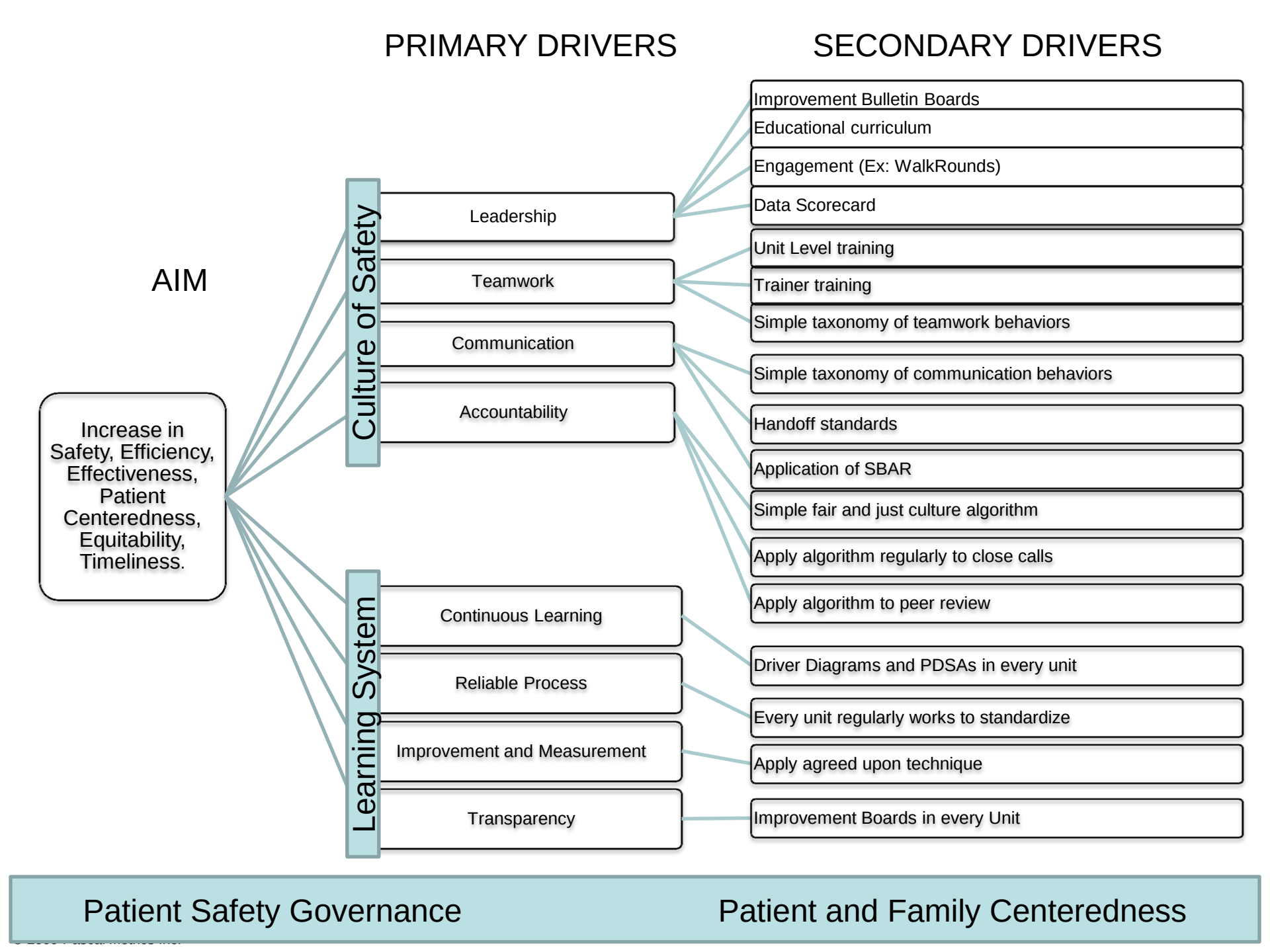
- Patient and family centered care is an organizational goal.
- Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into care planning and decision-making.
- Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in facility design; and in professional education as well as in the delivery of care.
- Open discussion of adverse events is supported and expected.

TO ACHIEVE SAFE AND RELIABLE CARE:

PATIENT SAFETY GOVERNANCE

- Board level measures of safety, risk and culture are included in dashboards.
- There is a process that incorporates Board members in Leadership WalkRounds.
- The Board and senior leaders message a simple set of organizational values.
- Leaders support an environment of appropriate accountability, transparency, and open disclosure.
- Leaders support and nurture a collaborative care culture based on effective teamwork.

- The Safety Framework
  - The elements in a system of safety
- Driver Diagram
  - Relates improvement aim to actions
- Execution Strategy
  - How do you take an aim, driver diagram or a strategy and make it work!


PRIMARY DRIVERS
SECONDARY DRIVERS
AIM
Increase in Safety, Efficiency, Effectiveness, Patient Centeredness, Equitability, Timeliness.
Culture of Safety
Leadership
Teamwork
Communication
Accountability
Learning System
Continuous Learning
Reliable Process
Improvement and Measurement
Transparency
Improvement Bulletin Boards
Educational curriculum
Engagement (Ex: WalkRounds)
Data Scorecard
Unit Level training
Trainer training
Simple taxonomy of teamwork behaviors
Simple taxonomy of communication behaviors
Handoff standards
Application of SBAR
Simple fair and just culture algorithm
Apply algorithm regularly to close calls
Apply algorithm to peer review
Driver Diagrams and PDSAs in every unit
Every unit regularly works to standardize
Apply agreed upon technique
Improvement Boards in every Unit
Patient Safety Governance
Patient and Family Centeredness

	Key Change Ideas	What will I do in… 30 days? (No resources, no approval, low barrier to entry)	6 months? (Minimal resources, supervisor approval, medium barrier to entry)	1-2 years? (Organizational change, high barrier to entry)
Leadership	**Yearly safety goals are set and include mortality, adverse events and reliable care.**	**Leaders agree to include goals.**	**Goals are set and shared throughout the organization/department. Each strategic goal/project is linked to a senior leader.**	**Goals are reviewed yearly and strategic planning is based on goals.**
Teamwork	**All caregivers are trained in teamwork and communication.**	**A method is selected for teaching team practice.**	**Schedule for all to be trained in teamwork practice.**	**Yearly education plan exists and incorporates team training.**

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Communication	All caregivers are trained in the use of SBAR.	Select a unit and collect SBAR training materials.	Train one department in the use of SBAR.	Hospital-wide implementation in the use of SBAR for standardized communication.
Accountability: Just Culture	A method exists to assist groups apply a fair and just accountability schema to adverse events.	The Board and executive leadership agree to adopt a Just Culture model.	Just Culture training begins.	The Just Culture schema is applied for individuals involved in an adverse event.

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Continuous Learning	There is a standard method to learn from adverse events and close calls.	Agreement is reached on developing a method to learn from adverse events and close calls.	Training in how to analyze information gathered from investigations of adverse events and close calls.	There is a process in place by which information learned from adverse events and close calls is used to improve processes to address safety issues.
Reliable Care Processes	Process reliability is an expectation and reliable design principles are to be used in improvement work.	Reliable design training is introduced to leadership and managers.	Training starts for improvement teams.	Reliable design is available to all staff. Measurement and monitoring system in place for process reliability.

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Improvement and Measurement	Staff measures their own processes and outcomes and uses the data to improve systems.	Staff introduced to the use of data for improvement.	Training on data collection and interpretation to use for improvement.	Measures are routinely collected by front line staff who use the information to improve safety in real time. Data are displayed so that it is visible to all staff.
Transparency	Creation of a transparent and defect identification and resolution process.	An Improvement Board with processes, outcomes, defect identification and resolution, is tested and implemented in one unit.	All departments across the facility have Improvement Boards.	There is a process in place by which senior management uses the learning from the Improvement Boards to drive decision making.

		What will I do in…		
	Key Change Ideas	**30 days?** (No resources, no approval, low barrier to entry)	**6 months?** (Minimal resources, supervisor approval, medium barrier to entry)	**1-2 years?** (Organizational change, high barrier to entry)
Patient Safety Governance	**Board level measures of safety, risk and culture are included in dashboards.**	**Discussion of selection of measures for dashboard.**	**Measures selected and prepared for dashboard.**	**Presence of a balanced scorecard that includes safety/risk matrix. Safety and Risk present together to Board.**
	There is a process that incorporates Board members in Leadership WalkRounds.			
	Message organizational values.			
Patient and Family Centeredness	**Healthcare practitioners listen to and honor patient and family perspectives and choices.**	**Select practitioners to develop plan to include patients.**	**Practitioners trained on interactions with patients.**	**Patients/families participate in care and decision making at the level they choose, including multidisciplinary rounds.**

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Take a moment to reflect on your own work. What will you incorporate from this session into your plans?