Through our Patient's Eyes
What are we Blind To?

3rd Annual Quality and Patient Safety Summit

Richard D. Guthrie, Jr., M.D.
CQO, Ochsner Health System

September 9, 2016

As Patients…
• We think that we’re going to be OK
• We certainly don’t think we’ll get harmed
• Most of us probably think that way…when we’re patients

System Realities…
• Healthcare is a high hazard and also high risk industry
• As an industry, we’ve lagged other high reliability industries in the adoption of safety science and have struggled with a true culture of safety
As Caregivers…

• We know we work hard, and we know that we care
• We can be blind, though, to the system vulnerabilities that are everywhere
• We “normalize the deviance” and unacceptable practices and standards gradually become acceptable – it just becomes the way it always works

Communication

• Have you ever experienced a time where you couldn’t get in touch with the right clinician in a timely fashion for your patient?
• Could this have hurt your patient?
• I measured this on one floor at Ochsner Medical Center – 12% of nurse calls at night went to the wrong provider
• Each of these delayed overall response by about 20 minutes
• At the risk of “beating a dead horse”, what would happen if there was a 20 minute delay in communication between an airplane and the tower?

Medication Reconciliation

• How many of you have you personally had an error on your medication list in the EMR where you get your care?
• How bad could this turn out for you? What’s the worse thing that could happen?
• Do you know what your organization’s Medication Reconciliation’s error rate is?

Routine Process Fail Routinely – Ochsner System

• Hand Hygiene
  – More than 2 out of 10 people fail to wash their hands going from patient to patient
• Medication Administration
  – Despite Bar-Coding, we still make about 400 medication errors a year that reach the patient
• Patient Identification
  – So far this year, we’ve conducted 1 procedure on the wrong patient, 2 unnecessary procedures because of a specimen error, and 5 procedures on the wrong side or site
Coordination of Care

Our Patient’s Wonder...in their words

• “You’re asking me the thing that two other providers asked me about earlier – do you coordinate with each other about my care?”
• “You’re telling me different things about what tests I am going to have, or what treatments I’m going to get”

It’s Great When We Use Them

“...very useful last night when knowing to f/u on a post-transfusion H&H where the pt required another unit of blood...”

“...when the primary service asked me to f/u on a midnight troponin. It was significantly elevated and I re-consulted cards who did a stat bedside echo and we initiated NSTEMI therapy for the patient. Had I not had the sign out, the troponin likely would not have been discovered til the primary team came in the next morning...”

Hand-off Tool in EMRs

We Have a Burning Platform
But: We Have Begun Our Safety Journey

A Personal Story... It was 1981

Concentrated “KCL for injection” on the floor of a hospital - 10 accidental deaths were reported in the first 2 years of Joint Commission’s sentinel event program (1996-97)

“Every system is perfectly designed to get the results it gets” - Paul Batalden, M.D

“The single greatest impediment to error prevention in medicine is that we punish people for making mistakes.”

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before the US Congress
Individual Blame or Fear Thereof

- Can create fear to speak up about mistakes (or possible mistakes)
  - Can reduce occurrence reporting
- Can prevent the discovery of system failures that lead to adverse events
- Can give a false sense of confidence that the “cause” was addressed while the system vulnerability remains

Just Culture Decision Guide

- Designed to be used by leaders to reliably and consistently make the right choice
- Separates the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy
COPE – Connecting with Our Peers through Empathy

- Patients are victims of errors…so are the care-givers who made them – they are the “Second Victims”
- COPE is a voluntary peer support program for emotional “first aid” for any health care provider when things go poorly for their patients
- The program is highly confidential
- Over 100 referrals in its 1st year!

We’ve made mistakes even when someone on the team knew that we were about to make it…

Psychological Safety & Impairment of Voice

Detriment to myself
Could look ignorant, incompetent, negative or disruptive
If I’m wrong

Benefit to someone else, or the organization
Voice
Can we stop and double check the patient ID?
If I’m right

Sent into Ochsner’s SOS system
Sent into Ochsner’s SOS system

Because it wasn’t orders and I did not tell anyone about a diet.

And next time I don’t answer you is because I’m busy so never again call me back with questions marks.

IS THAT UNDERSTOOD!!!

A Learning Culture – Way It Should Be

Thank you for having the courage to make sure we’re safe!

If I’m right

If I’m wrong

Benefit to other, or organization

Voice

Peer Professionalism Program

• Modeled after a program at Vanderbilt
• For isolated minor breaches in professional behavior on the part of a provider
• Uses peers in a respectful and non-judgmental way to message to a provider that:
  – A report was received
  – Specific behavior/performance was observed

Promoting Professionalism Pyramid

Level 1 “Awareness” Intervention

Level 2 “Guided” Intervention by Authority

Level 3 “Disciplinary” Intervention

No & Pattern persists

Apparent pattern

Single “unprofessional” incidents (merit?)

“Informal” Cup of Coffee Intervention

Vast majority of professionals - no issues - provide feedback on progress


Pichert et al, 2011.

Hickson & Pichert, 2012.

Hickson et al, 2012.

Pichert et al, 2013.

Talbot et al, 2013.
TeamSTEPPS – Training the Team

• Team Strategies and Tools to Enhance Performance and Patient Safety
• Evidence-based set of teamwork tools
• Aimed at improving outcomes by improving communication and teamwork skills among health care professionals

Ochsner Has Some New Signs!

Everyone Can Be a Leader in Safety

• We can all create the invitation to speak up:
  – “Hand washing is so important for our patients. Please remind me if you see me forget and I’ll do the same for you”
• What difference could that make for the team around you?
• What difference would that have made if your mentor told you that when you were a student?

Tomorrow

Someone who works at your organization will be hospitalized
Tomorrow
Someone who works at your organization will be hospitalized
What's going to go through their mind?

Maybe…
- Communication about my care
- Accurate medication reconciliation
  - How accurate was that again?
- The doctor on call knows about me, right…
- Everyone washes their hands for me, right…
- No one will make a huge mistake, right…

What Should Be Going Through Our Minds Today?

Conclusions
- There is a Compelling Need for Change
- We've started our journey – but it's a long one!
- Everyone of us can be leaders on this journey
- Today, let's all learn more about this journey and continue it together!!