How CPS Can Help you Implement QAPI in a Confidential Environment

DHSS Regional Meetings

Summer 2013

Center for Patient Safety
Delivering Safety Culture Solutions

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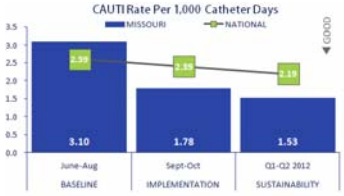
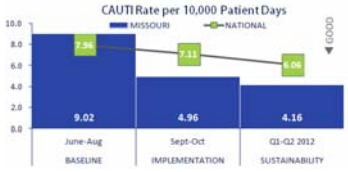
Conquering Chaos
THE HUMANITY & SCIENCE OF SAFE CARE





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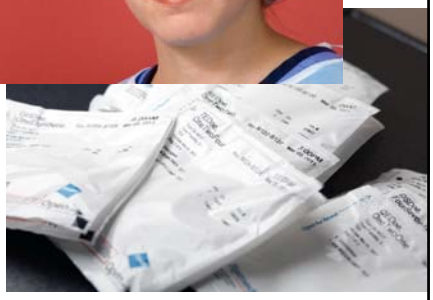
Safety Culture (IOM): An environment that encourages organizations to:

- Identify errors/surveillance
- Evaluate causes
- Take appropriate actions to improve performance in the future
- Measure impact of changes



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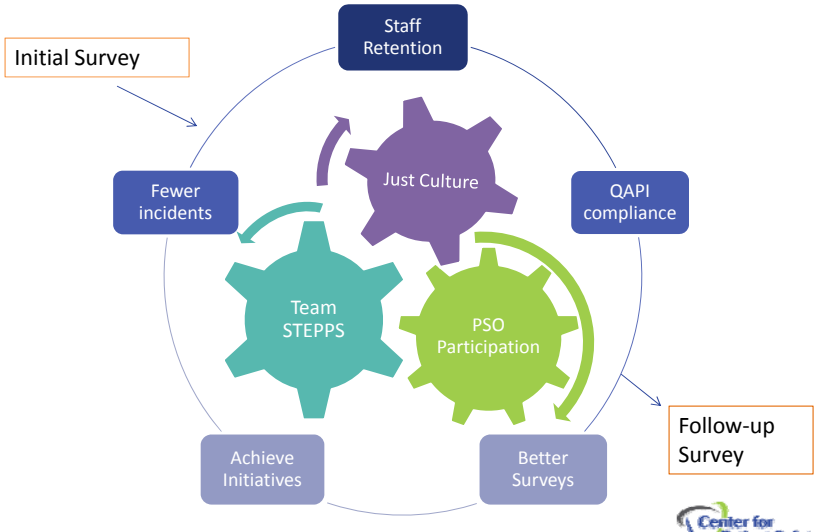
The Safety Culture Journey



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Essential Concepts:

- Health care is complex and risky
- Solutions are usually found in the broader systems context
- Identify and minimize hazards pro-actively
- Continuous improvement: there is always room to make it better
- We make mistakes.

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Using the Safety Culture Assessment to Affect Change

Culture assessments can be used to:

- Diagnose culture to identify areas for improvement
- Raise awareness about resident safety
- Evaluate safety interventions and track changes over time
- Conduct internal and external benchmarking
- Fulfill directives or regulatory requirements

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Dimensions of Safety Culture

These are the components measured by the survey:

- Training and skills
- Non-punitive response to mistakes
- Handoffs
- Feedback and communication about incidents
- Communication openness
- Supervisor expectations & actions
- Management support for resident safety
- Organizational learning
- Rating the facility for safety

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AHRQ HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

- Sample Questions:
  - "People support one another on this unit."
  - "In this unit, people treat each other with respect."
  - "We are actively doing things to improve patient safety."
  - "Staff feel like their mistakes are held against them."
  - "When an event is reported, it feels like the person is being written up, not the problem."

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CPS helps make survey simple

- Simple web-based administration
- Can help compare old results if you have them
- Report on current results
- Help with interpretation and follow-up
- Second survey to measure/demonstrate progress on identified dimensions

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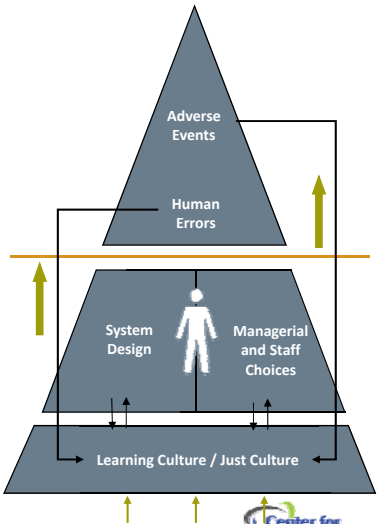
How Can We Improve?

Establish a Just Culture

What is a Just Culture?

- The program supports a learning culture
- Focuses on proactive management of system design and management of behavioral choices



Model from Outcome Engenuity

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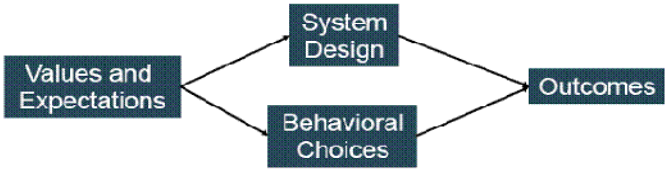
Determining Outcomes: Just Culture

The Just Culture Community

The Constraints



- Competing Values
- Limited Resources
- Fallible Human Beings
- and, the Laws of Physics

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Cornerstones of a Just Culture

Create a Learning Culture

- Eager to recognize risk at both the individual and organizational level
- Risk is seen through events, near misses, and observations of system design and behavioral choices
- Without learning we are destined to make the same mistakes

Source: Outcome Engineering

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Cornerstones of a Just Culture

Create an Open and Fair Culture

- Move away from an overly punitive culture and strike a middle ground between punitive and blame free
- Recognize human fallibility
  - Humans will make mistakes
  - Humans will drift away from what we have been taught

Source: Outcome Engineering

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Cornerstones of a Just Culture

Design Safe Systems

- Reduce opportunity for human error
- Capture errors before they become critical
- Allow recovery when the consequences of our error reaches the patient
- Facilitate our employees making good decisions

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Cornerstones of a Just Culture

Manage Behavioral Choices

- Humans will make mistakes. They are not a choice.
- Cultures will drift into unsafe places, with potentially risk choices
- Approach choice issues with coaching or discipline, depending on level of risk/recklessness

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Administrator/DON/DSN Role in a Just Culture

- You have the ability and responsibility to determine the culture
- Staff will defer to you
- "I don't know" is not a dirty word
- Investigation is important and valued
- Allow and encourage questions
- Teachers get better results than policemen

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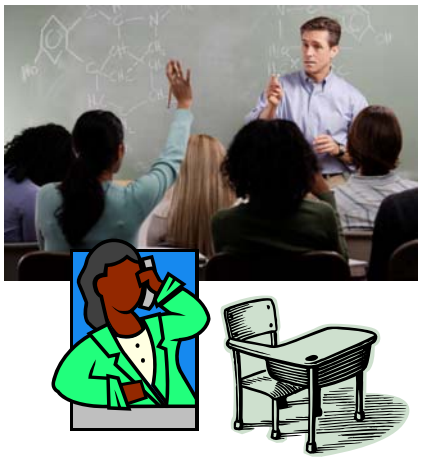
The Just Culture Process with CPS

- Regional half-day meetings for representatives of homes/organizations
- Education about duties, outcomes, investiga-tions and behaviors
- Collaborative support of group
- Periodic check-ins and sharing
- Integration with SOPS
- Available individual assistance



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TeamSTEPPS®

Strategies and Tools
to Enhance Performance
and Patient Safety

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care - www.ahrq.gov
PATIENT SAFETY
TRICARE

TeamSTEPPS for Long-Term Care

Key aspects:

- Team Structures
- Leadership
- Situation Monitoring/Awareness
- Mutual Support (Wing Man)
- Communication
- Teams include residents and families

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Background: U.S. Army Aviation

- Army aviation crew coordination failures in mid-80s contributed to 147 aviation fatalities and cost more than $290 million
- The vast majority involved highly experienced aviators
- Failures were attributed largely to crew communication, workload management, and task prioritization

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Teamwork Actions

- Recognize opportunities to improve resident safety
- Assess your current organizational culture and supporting components of resident safety
- Identify a teamwork improvement action plan by analyzing data and survey results
- Design and implement an initiative to improve team-related competencies among your staff
- Integrate TeamSTEPPS into daily practice

"High-performance teams create a safety net for your healthcare organization as you promote a culture of safety."

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The TeamSTEPPS Process

- Regional half-day meetings for representatives of homes
- Assistance with development of tools
- Collaborative support of group
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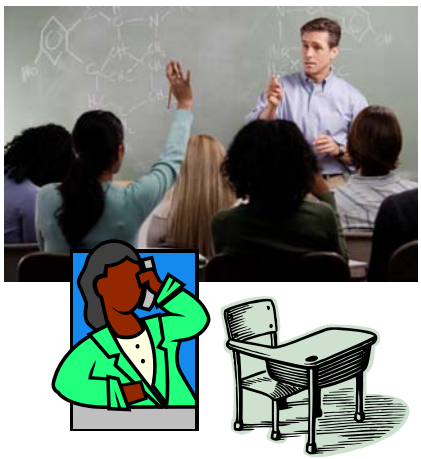
- Integration with SOPS
- Available individual assistance



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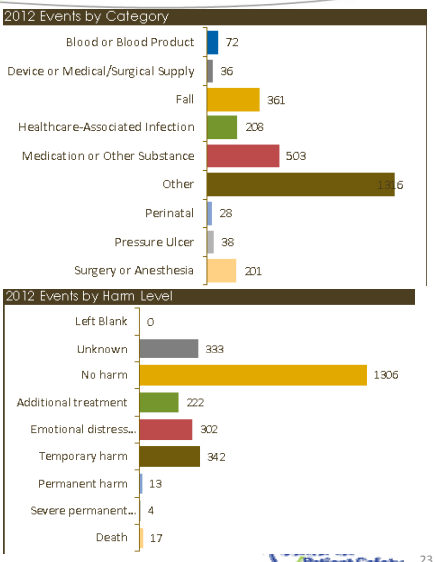
PSO: Large numbers for better learning in a confidential environment

Patient Safety Organization for LTC:

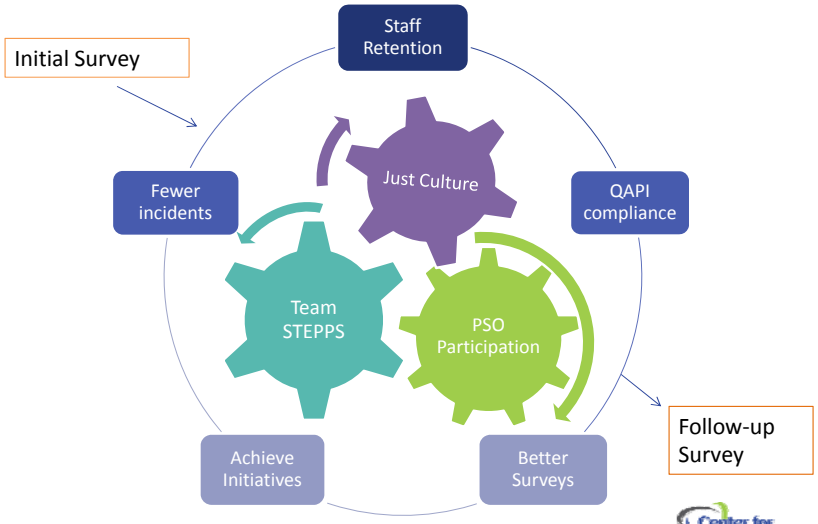
- Electronic reporting of events
- Standardized data format for internal and state-wide comparison and study
- Individual reports, customizable
- Learning based on trends, experiences
- Federal confidentiality



Patient Safety Organization

- Federal law
- Fully voluntary
- CPS: Non-profit, certified PSO
- Goal: gather, aggregate and study data in common formats to identify safety improvement opportunities
- Federal confidentiality protection for the work and the data
- Coach participants on safety journey
- Anticipated to begin signing up end of 2013

The Safety Culture Journey



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