On Erring and Caring: Accelerating Freedom from Harm

Patricia McGaffigan, RN, MS, CPPS I Vice President, Safety Programs
Institute for Healthcare Improvement/National Patient Safety Foundation
Class 11 Fellow, NPSF-AHA Patient Safety Leadership Fellowship Program
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My Disclosure

- I have nothing to disclose
- I am an a volunteer Board Member of the nonprofit Medically Induced Trauma Support Services (MITSS)
IHI and NPSF

To build systems of safety across the continuum of care
Objectives

• Describe the current state of patient and workforce safety
• Overview three recommendations for improving safety for patients and the workforce
• Identify at least one take away that you can implement immediately in your organization
A typical day in the office...

• Q: What are the top 5 errors that “a specific profession” makes?

• A: Here’s why I cannot and will not be able to answer that question...

• However I can talk about several of the top things that “certain professionals” do to ensure care is safe. What’s your word limit and how long do you have?
On error and harm…
In the aftermath...

Lonely
Punitive action
Physical patient harm
Shame & Blame
Careless
Incident Report
Imperfect
Leave Teaching
Leave Nursing
In hindsight...

• The recognition of human fallibility & limits
  – RN was working two FT jobs & taking doctoral courses
  – Working beyond human limits, fatigue; No one knew...but the RN

• Error was clearly unintentional
  – Systems & human factors were present

• What happened to this nurse?
How things could go much better...

- Wellness Resiliency Ppl/system
- Emotional patient harm
- Preventing future harm
- RCA2
- Just Culture
- High Reliability
- Peer support
- Sharing Apology
- Role Model “wrongness”
- Supporting learners
MEDICAL HARM IS THE THIRD LEADING CAUSE OF DEATH IN THE US
Let’s put this in context...
Patient Safety: A Public Health Issue

- Despite progress, preventable harm remains unacceptably frequent
- Total systems approach needed to generate change
- Initiatives can advance and improve...but are less likely to succeed and be sustained in the absence of cultures of safety
So What Does the Public Think?

- National survey: 2,536 adults from May-June 2017
- AmeriSpeak® Panel of NORC at the University of Chicago (representative of U.S. population)
- Online & telephone interviews using landlines & cell phones
- Margin of sampling error: +/- 3.2 percentage points

NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute. (2017). Americans’ Experiences with Medical Errors and Views on Patient Safety. CHICAGO, IL
Prevalence of Patient-Perceived Errors

Adults who have not experienced an error nor known someone who has experienced an error: 59%

- Adults who have personally experienced an error: 10%
- Adults who know someone else who has experienced an error: 20%
- Adults who report both of the above: 11%

NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute. (2017). Americans’ Experiences with Medical Errors and Views on Patient Safety. CHICAGO, IL
Types of Patient-Perceived Errors

- **59%** A medical problem was **misdiagnosed**
- **46%** Mistake was made during a test, surgery, or treatment
- **42%** Received a diagnosis that didn’t **make sense**
- **39%** Not treated with respect

NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute. (2017). Americans’ Experiences with Medical Errors and Views on Patient Safety. CHICAGO, IL
Other key highlights

- > 50% of error occurred in an outpatient setting
- Diagnostic errors and mistakes related to provider and patient communications were most common
- Harm included physical, financial, emotional, and family impact; often had long-term or permanent impact
- Patient was informed about error in less than 1/3 of cases; 1/2 of respondents reported error
- Most respondents believe that patients and families have a role to play in preventing medical error
Cultures of safety are vital

Ensure that leaders establish and sustain a culture of safety
Eight recommendations for achieving total systems safety

1. Ensure that leaders establish and sustain a safety culture
2. Create centralized & coordinated oversight of patient safety
3. Create a common set of safety metrics that reflect meaningful outcomes
4. Increase funding for research in patient safety & implementation science
5. Address safety across the entire care continuum
6. Support the healthcare workforce
7. Partner with patients and families for the safest care
8. Ensure that technology is safe and optimized to improve patient safety
“The single greatest impediment to error prevention in the medical industry is that we (continue to) punish people for making mistakes”

Lucian Leape
• Consistently, the most poorly rated area is “Nonpunititive response to error”
<table>
<thead>
<tr>
<th>Patient Safety Culture Composites</th>
<th>Average % Positive</th>
<th>s.d.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Teamwork Within Units</td>
<td>82%</td>
<td>5.91%</td>
</tr>
<tr>
<td>2. Supervisor/Manager Expectations &amp; Actions Promoting Patient Safety</td>
<td>78%</td>
<td>6.66%</td>
</tr>
<tr>
<td>3. Organizational Learning—Continuous Improvement</td>
<td>73%</td>
<td>7.44%</td>
</tr>
<tr>
<td>4. Management Support for Patient Safety</td>
<td>72%</td>
<td>9.14%</td>
</tr>
<tr>
<td>5. Feedback &amp; Communication About Error</td>
<td>68%</td>
<td>8.05%</td>
</tr>
<tr>
<td>6. Frequency of Events Reported</td>
<td>67%</td>
<td>7.37%</td>
</tr>
<tr>
<td>7. Overall Perceptions of Patient Safety</td>
<td>66%</td>
<td>8.50%</td>
</tr>
<tr>
<td>8. Communication Openness</td>
<td>64%</td>
<td>6.70%</td>
</tr>
<tr>
<td>9. Teamwork Across Units</td>
<td>61%</td>
<td>9.32%</td>
</tr>
<tr>
<td>10. Staffing</td>
<td>54%</td>
<td>9.34%</td>
</tr>
<tr>
<td>11. Handoffs &amp; Transitions</td>
<td>48%</td>
<td>10.37%</td>
</tr>
<tr>
<td>12. Nonpunitive Response to Error</td>
<td>45%</td>
<td>8.75%</td>
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</tbody>
</table>
Vulnerable Workplaces

Physical Harm

- More hazardous to work in health care than in mining, machinery manufacturing, and construction
  - More FTE days are lost due to occupational illness and injury in health care
- Health care professionals report that unsafe working conditions interfere with the delivery of quality care
- An RN or MD has a 5-6 times higher chance of being assaulted than a cab driver in an urban area
- It is easy to put the healing of others before our own health
Vulnerable Workplaces

Psychological Harm

- Lack of respect
  - A root cause, if not THE root cause, of dysfunctional cultures
  - 95% of nurses report it; 100% of medical students report it
- Lack of support; appreciation
- Incivility, moral distress
- Non-value add work, production pressures
- Scheduling demands and fatigue
- Poor design of work environments and work flows
Costs of inaction

- Burnout, lost work hours, workforce attrition & retention
- Less vigilance with safety practices, missed care -- resulting errors & harm to patients & workforce
- Workforce physical and emotional health harm & decline, including depression and suicide
- Productivity losses from absenteeism & presenteeism
The difference between “Doing” versus “Being”
Professionals need support to fulfill their highest potentially as healers

- Workforce safety, morale and wellness are essential for safe care
- Support that is routine and for adverse events
  - Attention to physical and emotional harm
  - Respect, recognition (DAISY), resources (3 R’s) & response
  - Accountability for behaviors
  - Fatigue management, ergonomic scheduling, peer support programs
  - Mindfulness, meditation, positive psychology
On Leadership
The Leadership Imperative

• Leaders & boards set the tone and core values for safety
  – Hold ultimate responsibility for system-based errors and their resulting costs

• Patient and workforce safety requires demonstrated dedication, understanding, and accountability from leaders in order to expect the same from others
Closing the Gap and Raising the Bar: Assessing Board Competency in Quality and Safety

Patricia A. McGaffigan, RN, MS, CPPS; Beth Daley Ullem, MBA; Tejal K. Gandhi, MD, MPH, CPPS

- Convenience sample survey of CEOs, board members, and safety, quality and risk leaders (SQLs); unpaired
- CEOs and board members self-report of activities, knowledge, and understanding
- SQLs belief about what CEOs & board members do, know, and understand
<table>
<thead>
<tr>
<th>Activity</th>
<th>Board Members’ Self-Report</th>
<th>CEOs’ Self-Report</th>
<th>SQLs’ Perception of Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient safety and quality dashboard at every board meeting</td>
<td>79 (68/86)</td>
<td>61 (30/49)</td>
<td>60 (195/326)</td>
</tr>
<tr>
<td>A workforce safety dashboard at every board meeting</td>
<td>33 (28/86)</td>
<td>8 (4/49)</td>
<td>18 (58/326)</td>
</tr>
<tr>
<td>Our quality and patient safety dashboard performance to others in industry</td>
<td>50 (43/86)</td>
<td>55 (27/49)</td>
<td>38 (124/326)</td>
</tr>
<tr>
<td>Our accreditation survey results/recommendations</td>
<td>65 (56/86)</td>
<td>82 (40/49)</td>
<td>57 (187/326)</td>
</tr>
<tr>
<td>Our publicly reported performance results</td>
<td>56 (48/86)</td>
<td>67 (33/49)</td>
<td>53 (172/326)</td>
</tr>
</tbody>
</table>
Leading a Culture of Safety: A Blueprint for Success

Download the full PDF report at: www.npsf.org/cultureofsafety
The Six Domains

- Establish a compelling vision for safety
- Value trust, respect, and inclusion
- Select, develop, and engage your Board
- Establish organizational behavior expectations
- Lead and reward a just culture
- Prioritize safety in the selection and development of leaders
How do we get safer?

• Take care of you (physical and emotional)
• Identify and take care of what matters to the patient
• Understand & address the system
• Commit to foundational and ongoing education
  • Safety & improvement science, RCA2
• Be transparent, speak up, report & respond
• Integrate mindfulness and high reliability
RCA²

Download the report: www.npsf.org/RCA2
Am you a “culture carrier” or “culture barrier”?
With gratitude for all that you do…

pmcgaffigan@ihi.org
DIDN'T UNDERSTAND THE QUESTION

GOT AWAY WITH "IT'S THE NEXT IDEA TO EXPLORE"