Enhancing Patient Quality and Safety with Compliance

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Content

• A successful compliance program enhances patient safety and quality
• A robust culture around disclosure, transparency and reporting is important to success
• Supportive tone at the top and system and structures are essential
How Compliance helps enhance Patient Quality and Safety

Three weeks after a non-surgical procedure to treat a brain aneurysm at Virginia Mason Hospital, Mary was injected with a toxic cleaning solution instead of either saline or the radiological dye routinely administered at the conclusion of the procedure. The containers were unmarked.

44,000 to 98,000 patient deaths per year from medical errors

*To Err is Human, Institute of Medicine (1999)*

How Compliance helps enhance Patient Quality and Safety

- Many of the tools and structure put in place to increase compliance also improve patient quality and safety, such as
  - Increased incident reporting catches issues before they escalate
  - Compliance with documentation improves tracking and trending quality and safety issues that impact care delivery
  - Linking compliance with departments such as quality, performance improvement, infection control, case management, risk and accreditation ensures a common approach and culture throughout the organization
Supportive tone at the top to enhance compliance, Patient Quality and Safety

- CEO led safety network
- Engaged consultant to help improve culture
- Conducted an event detection survey
- Began utilizing a new event classification system to identify negative events
- Analyzed two years of cases to review common causes of negative events
- Identified lack of compliance as a common cause of negative events
- Adopted and educated organization on safety value and principles
- Adopted communication tools to promote disclosure, transparency and reporting

Cultural Change In Focus

Systems Focus

- People are not perfect and will make mistakes
- System factors cause the majority of negative events
- Reliable outcomes are obtainable with the right mix of people and process

Individual Focus

- People who make mistakes are poor performers
- System performance will improve by removing poor performers
The Swiss-Cheese Effect

Multiple layers in process to prevent/detect - designed to stop mistakes and errors and increase compliance

Mistakes by people

Failed or absent defenses in the layers of a process

Negative Event

Adapted from James Reason, Managing the Risks of Organizational Accidents (1997)

Decrease in Serious Safety Events

71% reduction over two year period

Serious Safety Event Rate (SSER)

Rolling 12-month average of serious safety events per 10,000 adjusted patient days
People Causes of Events

<table>
<thead>
<tr>
<th>Common Cause</th>
<th>Evidenced by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Thinking</td>
<td>Tunnel vision</td>
</tr>
<tr>
<td></td>
<td>Mindset - bias based on pattern or preconceived notion</td>
</tr>
<tr>
<td></td>
<td>Failure to find or test the truth of something</td>
</tr>
<tr>
<td>Compliance</td>
<td>Indifference – careless, informal or casual attitude towards following rule or expectations</td>
</tr>
<tr>
<td></td>
<td>Shortcut – deliberate, conscious act to take a quicker route that deviates from optimal path</td>
</tr>
<tr>
<td></td>
<td>Reckless</td>
</tr>
<tr>
<td>(Consciousness) Attention to Detail</td>
<td>Inattention – preoccupation and inattentive practices leading to skill based errors; divided or diverted attention</td>
</tr>
<tr>
<td></td>
<td>Lapse</td>
</tr>
<tr>
<td>(Competency) Knowledge</td>
<td>Inadequate knowledge – lacking competency in job related knowledge</td>
</tr>
<tr>
<td>Communication</td>
<td>Incorrect assumption – assumption that something is true that in fact was wrong</td>
</tr>
<tr>
<td></td>
<td>Misinterpretation</td>
</tr>
</tbody>
</table>

System Causes of Events

<table>
<thead>
<tr>
<th>Common Cause</th>
<th>Evidenced by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture</td>
<td>Critical thinking</td>
</tr>
<tr>
<td></td>
<td>Operational leadership</td>
</tr>
<tr>
<td></td>
<td>Compliance</td>
</tr>
<tr>
<td></td>
<td>No collaboration</td>
</tr>
<tr>
<td></td>
<td>Lack of error prevention expectations and accountability for expectations to govern individual decision making and compliance</td>
</tr>
<tr>
<td>Process</td>
<td>Omitted actions</td>
</tr>
<tr>
<td></td>
<td>Inadequate interface</td>
</tr>
<tr>
<td></td>
<td>Ineffective process outlines to ensure reliable performance including checks, interface between departments and sequencing of steps</td>
</tr>
<tr>
<td>Policy &amp; Protocol</td>
<td>Usability</td>
</tr>
<tr>
<td>Structure</td>
<td>Collaborative mechanism</td>
</tr>
</tbody>
</table>
Action Plans & Strategy

- **Culture**
  - Change in focus to system as well as individual
  - Link decisions to safety
  - Adopted a safety value: Every person assumes responsibility, intervenes and is actively caring about safety

- **Personal responsibility**
  - Self checking during routine acts
  - Develop a monthly patient story and tell at the start of meetings

Action Plans & Strategy

- **Commitment**
  - Enhance daily report with safety & compliance questions/assessment
    - Create an organization action list with action items
    - Focus on encourage reporting of incidents/events

- **Questioning attitude**
  - Institute an organization-wide policy of transparency that sheds light on all adverse events and patient issues
  - Utilize crucial conversations skills
  - Adopt a protocol to raise concerns
Action Plans & Tools

- **Adhere to standardized processes**
  - Set clear expectations & follow up with observations and feedback
  - Data availability on a more real time basis

- **Communicate clearly**
  - Utilize communication tools
  - Ask clarifying questions

- **Support and trust each other**
  - Just culture
  - Peer checking and feedback

Transparency & Reporting
Transparency & Reporting

<table>
<thead>
<tr>
<th>When I face:</th>
<th>Traditional Behavior:</th>
<th>Systems Behavior:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing material or</td>
<td>• Fix it without bothering managers or others</td>
<td>• Remedies immediate situation but also lets the manager and others know</td>
</tr>
<tr>
<td>information</td>
<td></td>
<td>when the system has failed</td>
</tr>
<tr>
<td>Other’s errors</td>
<td>• Seamlessly correct the error for others – without confronting the other</td>
<td>• Lets others know when they have made a mistake with the intent of creating</td>
</tr>
<tr>
<td></td>
<td>person about their error</td>
<td>learning, not blame</td>
</tr>
<tr>
<td>My errors and problems</td>
<td>• Creates an impression of never making mistakes</td>
<td>• Lets manager and others know when they have made a mistake so others can</td>
</tr>
<tr>
<td></td>
<td></td>
<td>learn from their error</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Communicates openness to hearing about their errors discovered by others</td>
</tr>
<tr>
<td>Subtle opportunities to</td>
<td>• Committed to the current way of doing business</td>
<td>• Questions why do we do things this way? Is there a better way of providing</td>
</tr>
<tr>
<td>improve the system</td>
<td>• Understands that’s the way things work around here</td>
<td>the service to the patient?</td>
</tr>
</tbody>
</table>

Encourage a Questioning Attitude

Top 3 Statements to Encourage Critical Thinking¹

1. “What do you think?”
2. “That is an interesting question”
3. “Let’s explore this”

Encourage questions by inviting questions and positively reinforcing questions when asked.

¹Rubenfeld, “Critical Thinking Tactics for Nursing”
Raise a Concern – ARCC

Ask a question
Make a Request
Voice a Concern
Use Chain of command

Protocol for indicating and escalating a concern

Ask Clarifying Questions

Ask clarifying questions:
• In all high risk situations
• When information is incomplete
• When Information is not clear

Why…
To ensure that you do not make a decision based on a wrong assumption, make sure that you really understand what’s being communicated.

How…
Phrase your questions so that the answer you receive gives you an answer that improves your understanding of the information.

Asking clarifying questions can reduce the risk of making an error by 2½ times!
Self Check – Validate and Verify

**Validate:** Does the situation make sense to me?

**Verify:** Check with an independent, qualified source

Questions and Answers
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