Innovation & Compliance

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OVERVIEW

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Innovation & Compliance
Design Thinking
Q&A

THE RISK AUTHORITY
STANFORD

ABOUT US

The Risk Authority Stanford

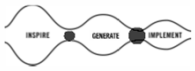


Stanford HEALTH CARE
STANFORD MEDICINE

Stanford Children's Health

Stanford | MEDICINE

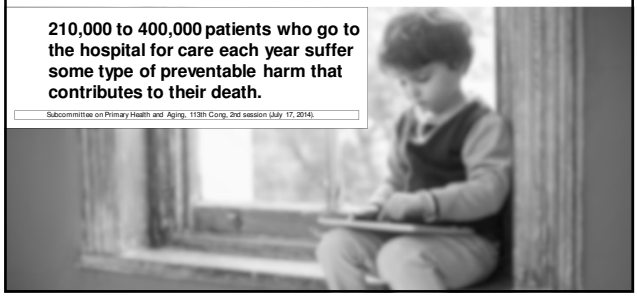
ABOUT US



THE NEED FOR INNOVATION

210,000 to 400,000 patients who go to the hospital for care each year suffer some type of preventable harm that contributes to their death.

Subcommittee on Primary Health and Aging, 113th Cong, 2nd session (July 17, 2014).



THE NEED FOR INNOVATION

Risk Management has not delivered on its promise.

PROVING THE NEGATIVE

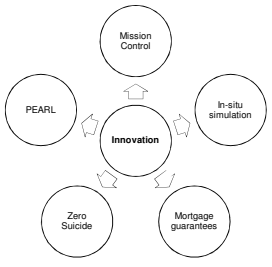
A good compliance officer will keep leadership informed when they find a problem and that they've fixed it. Really good ones will sit down every once in a while and say. 'What if we hadn't found this, we could have been like others who waited several years until the government found it."

Roy Snell, Chief Executive
Society of Corporate Compliance and Ethics

THE NEED FOR INNOVATION

We can improve the patient experience through empathy, expertise and technology.

PROACTIVE RISK MANAGEMENT



THE VALUE OF COMPLIANCE

83% of compliance professionals say their program prevented misconduct at least once in the last two years.

46% said their program stopped problems before they happened on six or more occasions in that time span.

Society of Corporate Compliance and Ethics

THE CHALLENGES OF INNOVATION

Solving the wrong problems
Not enough resources or incentives
Choosing the wrong solutions
Failing to sustain change
Not proving impact in human and financial terms

WHAT IS DESIGN THINKING?

Design thinking a adopting the mindsets of designers for solving problems outside the traditional fields of design.

WHAT IS DESIGN THINKING?

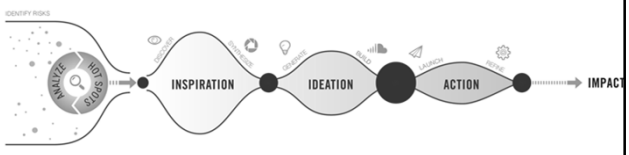
The designer's mindset.

Creative confidence	Deep empathy	Radical collaboration	Data & People	Go wide to go narrow	Rapid prototyping
					

WHAT IS DESIGN THINKING?

Design thinking is a proven methodology for problem-solving and innovation.

WHAT IS DESIGN THINKING?



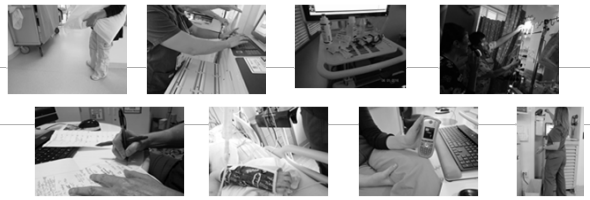
Risk strategy **People-centered design** **Improvement science**

PROJECT EXAMPLE

How might we prevent pediatric medication administration errors?

EMPATHY

We spent a couple of hours building empathy with with nurses, patients, and families on the ward.



DATA

Our data indicated significant losses due to medication administration errors.

SYNTHESIS

We unpacked our notes, making sense of what we had learned.



INSIGHTS

Nurses have been trained in safety, but are often distracted by patients and families.

Patients and families care a great deal about safety but don't always know what to look out for. Whether something is going seriously wrong or not, often looks exactly the same to them.

Some patients and families try and be alert and protective all the time (which is exhausting), and some focus on what they are familiar with.

"I don't know what I should be watching out for. I guess I watch whether a nurse washes her hands – that tells me if she's diligent. That's not very sophisticated, but that's all I understand.

- Father of a three year old.

"Sometimes the silence during meds time feels awkward. Often, I think the patient or family says something to make it less so – which distracts me as well."

– Nurse.





1. EMPATHY
Our team spent several hours on the ward seeking to understand the experiences of nurses, patients, and family in medication administration.

2. DEFINE
We shared our insights with the frontline nurses who gave feedback.

The nurses selected the most important targets to improve.

3. IDEATE
In two workshops, nurses generated ideas that met their needs.

They found new ways to helpfully involve patients and families in safety.

4. PROTOTYPE
Our team took the ideas and helped to evolve them.

Nurses, patients, and families gave us great feedback along the way.

4. TEST
Frontline nurses tested the ideas on the ward.

Over a two-week period, they tested and refined them.

We collected feedback regarding their efficacy and the design thinking process.

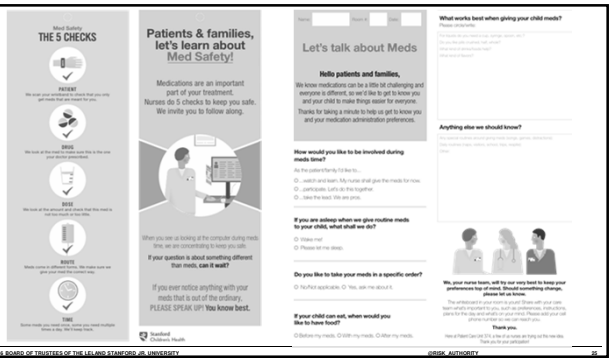
MEDPREF

A communication tool that invites patient and family to indicated their level of comfort in participating during medication administration and to share their preferences and knowledge of what works best. Knowing these important details about their patients, nurses can better plan for and administer the meds.

"Med pref makes the hospital feel like a luxury hotel while allowing the nurse to save time, energy and repetitive conversations understanding the family's desires.
–Nurse

"When you feel so anxious about everything going on with your child, this makes you feel you are a little bit in control. I love it."
- Patient's Mother

"This is great. It usually takes time before nurses get to know me. Here we have it all on the same page. I want this during admissions."
– Patient



EARLY RESULTS

Pre/post survey

- 40% Increase in patient/family awareness of medication safety
- 55% reduction in recalled medication administration interruptions from patients and families after using the tools.
- 100% of participating nurses stated they are more likely to participate in improvement projects as a result of this project.

FEEDBACK ON THE PROCESS

"We should do more projects like this. This is fun."
– Nurse

"These concepts could change people's lives."
– Nurse

"Improvement work angers me. It always fails. These people are telling me to do my job when they don't know how to do it. But, when we do include the frontliners in the process, and get feedback from the nurses in an ongoing basis, it works. This is real empowerment."
– Nurse Manager

"This is the first time that we've had MORE nurses participate in the second meeting. Unbelievable."
– Nurse Educator

"This is exactly the kind of work we need to be doing. What can I do to support?"
–CNO

DESIGN THINKING AND RISK INNOVATION

Helps you find the right problems to solve
Is good use of resources
Identifies the best solutions
Gives you the best chance of sustained change
Proves its impact in satisfaction and outcomes

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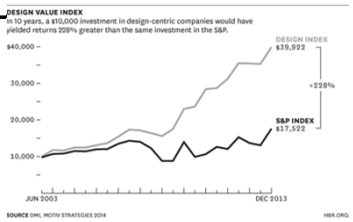
DESIGN THINKING AND RISK INNOVATION



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DESIGN THINKING RESOURCES

Innovator's Handbook e-book – TRA Stanford
Design Thinking, HBR –Tim Brown
Stanford School of Professional Development
IDEO University
Acumen+ IDEO Design Kit.

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ACKNOWLEDGEMENTS

Our colleagues at The Risk Authority Stanford
The Board of SUMIT Insurance Company
CQCE, Stanford Children's Health
Patient Advisory Council, Stanford Children's Health
Local Improvement Team, PCU 374 Stanford Children's Health

Thank you.

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