Creating a Culture in Support of Patient Safety

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Session Objectives

• Recognize leadership methods that detect and address patient safety gaps
• Determine the elements of a system needed to address safety risks and hazards
• Identify methods to assess your safety culture and apply these concepts to your organization

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Virginia Mason

- Integrated health care system
- 501(c)3 not-for-profit
- 336-bed hospital
- Nine locations
- 500+ physicians

- 5,500+ employees
- Graduate Medical Education
- Research Institute
- Foundation
- Virginia Mason Institute

What is Culture?

The total pattern of human behavior... embodied in thought, speech, action, and artifacts

A complex of typical behavior or standardized social characteristics peculiar to a specific group, occupation, or profession

Webster’s 3rd New International Dictionary
Safety Culture Defined

- Product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management
  - Communications founded on mutual trust
  - Shared perceptions of the importance of safety
  - Confidence in the efficacy of preventive measures


Six Dimensions

- Create a compelling safety vision
- Value and empower personnel
- Leader engagement in patient safety improvement efforts
- Lead by example
- Focus on system issues rather than on individual error
- Quest for improvement (even if already good)

Sara J. Singer, Harvard University and Anita L. Tucker, University of Pennsylvania, August 2005
Five Features

That help high reliability organizations work well when facing unexpected situations

- A preoccupation with failure
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise
- Reluctance to simplify interpretations of issues or risks

© 2011 The Health Foundation Originally published as Research scan: High reliability organizations

Four NQF Safe Practices

- Creating and Sustaining a Culture of Safety
  - Leadership Structures and Systems
  - Culture Measurement, Feedback, and Intervention
  - Teamwork Training and Skill Building
  - Identification and Mitigation of Risks and Hazard
Nemawashi

To prepare the soil for planting/transplanting a tree so that it will live
Nemawashi Gauge

Baseline: _____ Q1: _____ Q2: _____ Q3: _____ Q4: _____ Target: _____

0-3

4-6

7-10

Q __ ACTION
1. __________________
   __________________
2. __________________
   __________________
3. __________________
   __________________

Nemawashi Gauge Domains

- Leader Preparation
- Genba Presence
- Creating Line of Sight
- Daily Management
- Staff Readiness/Engagement
Leader Preparation

• Our leadership team’s capability and capacity to plan, facilitate and implement kaizen work using three foundational elements.
  1. No vacancies in key positions and majority of positions in role for at least six months
  2. Have received training and can provide training in organizational improvement method
  3. 50% of key team members have completed training in improvement method

Genba Presence

• Genchi Genbutsu (“go and see”) helps leaders understand the daily work of our team and the perspective of our patients
  1. Process in place that supports consistent rounding
  2. Standard process for the walk
  3. Standard process for follow-up of issues
Creating Line of Sight

• The way we connect the dots between what we do and why we are doing it and support accountability.
  1. Specific targets for tracking team progress and connection to organizational work.
  2. Work plan or other systematic method to track items being worked on.
  3. Discussion and tracking of staff ideas.

Daily Management

• Management system that supports teams ability to:
  1. KNOW: What their product is, understand demand and capacity and have a visual method to communicate
  2. RUN: Understand and manage normal and abnormal conditions; daily standard work.
  3. IMPROVE: Use daily management data to improve their work.
Staff Readiness/Engagement

• Every worker’s experience, every day:
  1. I am treated with **dignity and respect** everyday by everyone I work with
  2. I have the knowledge, skills and tools (**support**) to do (and **improve**) my job
  3. I am recognized (**appreciated**) and thanked for my contributions?

Paul O’Neill

Summary

• Leadership
• Transparency
• Improvement
• Accountability
• Engaging Staff
Transforming Healthcare
Creating a Culture in Support of Patient Safety
Requirements for Transformation

Sense of Urgency: Health Care Challenges

- 1999 Institute of Medicine Report – To Err is Human
  - Poor quality health care = 3% defect rate and costs the U.S. billions of dollars
  - Health care is unaffordable and unavailable to millions of people
  - Health care workers are negatively impacted by unreliable systems
The Virginia Mason Quality Equation

\[ Q = A \times \frac{(O + S)}{W} \]

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste

Transforming Healthcare

FROM
Provider First
Waiting is Good
Errors are to be Expected
Diffuse Accountability
Add Resources
Reduce Cost
Retrospective Quality Assurance
Management Oversight
We Have Time

TO
Patient First
Waiting is Bad
Defect-free Medicine
Rigorous Accountability
No New Resources
Reduce Waste
Real-time Quality Assurance
Management On Site
We Have No Time
The Virginia Mason Production System

We adopted the Toyota Production System key philosophies and applied them to healthcare

1. The patient is *always* first
2. Focus on the highest quality and safety
3. Engage all employees
4. Strive for the highest satisfaction
5. Maintain a successful economic enterprise
Guiding Vision: Hippocratic Oath

First, do no harm

Priority Zero Defects

First priority, zero defects

Quality and Safety

- Embed mistake proofing into everything we do
- Patient Safety Alert (PSA) System
  - Every employee is a safety inspector
  - Standard Work including leadership response
Are We Ready for Change?
Nemawashi Gauge

Baseline: ____  Q1: ____  Q2: ____  Q3: ____  Q4: ____  Target: _____

Leadership Preparation

Intro to VMPS  VMPS General Education  VMPS Leadership Training  VMPS Certification  VMPS Fellowship
Creating a Versatile Leadership Team

Genba Presence

Go to the place, look at the process, talk with the people
PeopleLink Board Example

1. **Our Focus and Purpose**: What are our key messages? (Bar chart)
   - Our Team
   - Our Metrics
   - Our Goals

2. **Team Progress**: Supporting data (pie chart)
   - Supporting data
   - Supporting data
   - Supporting data

3. **Current Work**: Our Customer Experience (time series graph)
   - Today’s Work (time series graph)

4. **Turn Your Ideas into Action**: We Need Your Ideas On... (time series graph)
   - Start Everyday Lean Ideas
   - Slack Everyday Lean Ideas
**Daily Management**

Virginia Mason Leaders Have Two Jobs

1. **RUN** their business
2. **IMPROVE** their business

**Engage all Employees**

Employees trained in VMPS

Involving employees in improving *their own work* with ELI, RPIW, & Kaizen
Employee Engagement: Sterile Processing

Defect by Root Cause (Process Accountable)

Defect by product grouping

Defect by Risk to the Patient (Red, Orange, Yellow)

Maintain a Successful Economic Enterprise

Virginia Mason Net Margin (in Millions)

Shared Success Program

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Questions?

A lean journey is a learning journey. Let us help you.