Session Objectives

1. Appreciate the spectrum of behaviors that undermine a culture of safety;
2. Articulate an evidence-based approach to addressing behaviors that undermine a culture of safety; and
3. Understand how to deliver Cup of Coffee and Espresso conversations.
Addressing Behaviors that Undermine Safety Culture

Pursuing Reliability

Definition: “Failure free operation over time... effective, efficient, timely, pt-centered, equitable”

Requires:
- Vision/goals/core values
- Leadership/authority (modeled)
- A safety culture = willingness to report and address
  - Psychological safety
  - Trust


Addressing Behaviors that Undermine Safety Culture

Professionalism and Self-Regulation

- Professionals are willing to engage in all aspects of the job – tedious or otherwise – to the best of their ability.
- Professionals commit to:
  - Technical and cognitive competence
  - Clear and effective communication
  - Being available
  - Modeling respect
  - Self-awareness
- Professionalism demands self- and group regulation

Checklists: The Keys to the Kingdom...

Atul Gawande’s ‘Checklist’ For Surgery Success

Speaking about dealing with unexpected challenges in medicine, Atul Gawande – a surgeon who writes for The New Yorker when he’s not at his day job at Harvard Medical School – relates a story about a man who came into an emergency room with a stab wound.

“Now, we actually wanted to do both in day to day...”

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December, 2015

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But wait...

- Conclusions:
  Adjusted risk of death; surgical complications; SSIs; wound complications, 30-day mortality…

**No Difference...**

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**The Right Balance**

- Intentionally Designed Systems
- Professional Accountability

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Addressing Behaviors that Undermine Safety Culture

Transition from “Disruptive” to “Behaviors that Undermine a Culture of Safety”

- A safety culture is the overarching goal
- Disruptive behavior is counter to...
- Individuals are accountable to promote and protect the safety culture of the organization...

Case: Whistling a Tune

The following event was reported to you through your electronic event reporting system:

- “Dr. Surgeon was scheduled to perform procedure. Once in the OR, the team attempted to perform a ‘time out’. Dr. Surgeon asked everyone to ‘listen carefully,’ then as the process started Dr. Surgeon began whistling a tune. ‘We believe it was the Mickey Mouse Club theme song.’”
Addressing Behaviors that Undermine Safety Culture

Represents a threat to safety?

1. Strongly Agree
2. Agree
3. Uncertain
4. Disagree
5. Strongly Disagree

If this event occurred in your org, what % of the time would it be reported?

1. 0%-20%
2. 20%-40%
3. 40%-60%
4. 60%-80%
5. 80%-100%
If reported, what % of the time would a medical leader have a conversation with Dr. Surgeon?

1. 0%-20%
2. 20%-40%
3. 40%-60%
4. 60%-80%
5. 80%-100%

What are behaviors that undermine a culture of safety?

Why are we so hesitant to act?
Addressing Behaviors that Undermine Safety Culture

1981 New Nurse
OB - Dr. X

Passive
Aggressive

No No No
Definition of Behaviors That Undermine a Culture of Safety

- Interfere with ability to achieve intended outcomes
- Threaten safety (aggressive or violent physical actions)
- Create intimidating, hostile, offensive (unsafe) work environment
- Violate policies (including conflicts of interest and compliance)

It’s About Safety

Excerpts from Vanderbilt University and Medical Center Policy #HR-027, 2010
Addressing Behaviors that Undermine Safety Culture

**Diagram:**
- One figure speaking: "Someone else will say something..."
- Another figure sitting: "Barrier"

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To “do something” requires more than a commitment to professionalism and personal courage.

It requires a plan (people, process and systems).

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**Essential Elements to Promote Reliability**

**PEOPLE**
- Committed Leadership
- Project Champions
- Implementation Teams

**PROCESS**
- Clear Goals and Values
- Policies and Procedures
- Sufficient Resources
- Tiered Intervention Model

**SYSTEMS**
- Tools, Data and Metrics
- Reliable Review Process
- Training
What Are “Surveillance Tools”? 

- Risk Event Reporting System
- Patient Relations Department
- Staff Concerns
- Hand Hygiene Performance
- Surgical Bundle Compliance

Called Dr. __ re: change in pt status...came 25 min later, looked at pt, publicly yelled at me, “you lied... pt okay... don’t call again.”...felt threatened.

Refused to do a time out before surgery, .... said, “we’re all on the same page here.”

Dr. __ refused to re-gown and re-glove during colorectal surgery. Said, “I don’t agree with that part of the bundle.”

Confidential and privileged information under the provisions set forth in T.C.A. §§ 63-1-150 and 68-11-272; not be disclosed to unauthorized persons.
Addressing Behaviors that Undermine Safety Culture

**RN:** We paged the APRN four times to come see the patient. She never came.

**RN:** One APRN said, “Well, are you going to push the IV med or are we going to stand around all day?”

**RN:** [The APRN] gave me an off-protocol order...I tried to speak up...APRN responded, “I’m driving the treatment plan here, not you.”

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**Co-Worker Observation Reporting System: VUMC Physicians – 3 years**

- 3.5% of physicians associated with > 40% of reports
- 87% of physicians association with NO reports in 3 years

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Co-Worker Observation Reporting System: National Comparison

1% of physicians associated with 61% of reports

97% of physicians are associated with NO reports in 3 years

Promoting Professionalism Pyramid

No ∆ Level 3 "Disciplinary" Interv

Pattern persists Level 2 "Guided" Authority Interv

Apparent pattern Level 1 "Awareness" Interv

Single "unprofessional" incidents (merit?) "Informal" Cup of Coffee Intervention

Vast majority of professionals - no issues - provide feedback on progress

*Includes CMS-defined "condition level" and "immediate jeopardy" safety-related complaints

Ray, Schaffner, Federspiel, 1985
Hickson, Pichert, Webb, Gabbe, 2007
Pichert et al, 2008
Madden et al, 2009
Hickson et al, 2010
Hickson & Pichert, 2011
Hickson et al, 2012
Pichert et al, 2013
Talbot et al, 2013
Back to the case: Whistling a tune

Dr. Surgeon asked everyone to ‘listen carefully,’ then as the process started Dr. Surgeon began whistling a tune. ‘We believe it was the Mickey Mouse Club theme song.’

So what kind of conversation?

For a single “event”…

Informal Conversation
Regular (Cup of Coffee)
(see handout)
Addressing Behaviors that Undermine Safety Culture

Principles for “Informal” Conversations

- Model respect and seek to maintain trust
- When possible share in a private area
- Avoid tendency to downplay ‘event’
- Balance empathy and objectivity
- Anticipate range of responses (push-backs)

See Handout:

6. Your role (even as “the chief”):
   - To report a single “disturbance”
   - To let the colleague know that the behavior/action was noticed (surveillance)
7. It’s not a control contest
8. Don’t expect thanks
9. Know message and “stay on message”
10. Know your communication style (and your buttons)
Addressing Behaviors that Undermine Safety Culture

Having the “Informal” Conversation

See Handout:

- Offer appreciation (if you can): “You’re important, if you weren’t, I wouldn’t be here.”
- Use “I” statements: “I heard…,” “I saw…,” “I received…”
- Avoid “you” statements...
- Review incident, provide appropriate specifics
- Ask for colleague’s view...pause...
- Respond to questions, concerns...

Closing:

- Appreciation, affirmation
- Empathy: “Now I feel I understand...”
- Accountability: “But we’ve all got to respond professionally...”
- Reminder of behavior standards: “incident did not appear consistent with...”
- If asked what to do use phrases: "reflect on the issues, think about ways to prevent recurrence."
- If appropriate: conversation confidential, known only to...
Addressing Behaviors that Undermine Safety Culture

Having the “Informal” Conversation

**Conversation is NOT:**

- A control contest
- Therapy (for the individual or yourself)
- A hierarchical conversation
- An enabling conversation
- An opportunity to address multiple issues

Now it’s your turn…
Addressing Behaviors that Undermine Safety Culture

Essential Elements to Promote Reliability

- **PEOPLE**
  - Committed Leadership
  - Project Champions
  - Implementation Teams

- **PROCESS**
  - Clear Goals and Values
  - Policies and Procedures
  - Sufficient Resources
  - Tiered Intervention Model

- **SYSTEMS**
  - Tools, Data and Metrics
  - Reliable Review Process
  - Training

But wait, does any of this really work?
Addressing Behaviors that Undermine Safety Culture

**PARS® Process - Does it work?**

- Improves physicians' prescribing, clinical decision making
- Improves hand hygiene practices: From 50% to >95% compliance
- Reduces malpractice claims & expenses: By >70%
- Addresses behaviors that undermine a culture of safety

**Since FY 2000, PARS® has identified 1368 U.S. physicians as high risk**

- Successfully completed intervention process or are improving
  - 806 Physicians
- Unimproved/worse
  - 158 Physicians
- Departed organization unimproved
  - 68 Physicians

Departed before follow up = 123 - First follow up next year = 213

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Addressing Behaviors that Undermine Safety Culture

Reduce Physician Malpractice Claims and Costs

<table>
<thead>
<tr>
<th>Claims Dollars Paid* Per Physician Year Before and After First PARS Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 1st Intervention</td>
</tr>
<tr>
<td>Dollars Uncapped</td>
</tr>
<tr>
<td>Dollars Capped ($2MM/Circumstance)</td>
</tr>
</tbody>
</table>

*Naive PARS High-Risk Physicians with at least one year of follow-up data, p < .001
**No claims for these physicians exceeded the $2MM cap after interventions

Vanderbilt Medical Malpractice Suits Per 100 Physicians

<table>
<thead>
<tr>
<th>Year</th>
<th>SVMIC</th>
<th>VUMC</th>
<th>Tort Reform in TN</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>15</td>
<td>10</td>
<td>2008 – Cert. of Merit w/ Notice</td>
</tr>
<tr>
<td>2005</td>
<td>12</td>
<td>8</td>
<td>2011 – $750K Cap</td>
</tr>
<tr>
<td>2007</td>
<td>10</td>
<td>5</td>
<td>2012 – Address unprofessional or unsafe behavior</td>
</tr>
</tbody>
</table>

ID & intervene on high-risk VUMC physicians (PARS®) 2003 – Claims reviews w/ leaders 2005 – 2007 Standardized MM&Is; Faculty Disclosure Training 2007 – Allocation rebate program 2012 – Address unprofessional or unsafe behavior

VUMC Risk Prevention Initiatives

SVMIC

VUMC

Tort Reform in TN

ID & intervene on high-risk VUMC physicians (PARS®) 2003 – Claims reviews w/ leaders 2005 – 2007 Standardized MM&Is; Faculty Disclosure Training 2007 – Allocation rebate program 2012 – Address unprofessional or unsafe behavior

*Data source: SVMIC provided an affiliate health insurance company, with a claim of $2,000 or more in VUMC physicians, offered Cert. of Merit, 2006 to 2008 only, outside of lengthy and complex hospital and physician's faulted event. October 2012, 2015

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Hand Hygiene Improvement Strongly Correlates with Low Infection Rates

- Each data point indicates the VUMC-wide monthly HH adherence (x-axis) and infection rates (y-axis) between Jan 2007-Aug 2012
- As adherence goes up, infection rates go down


Case: House call

The following event was reported to you through your electronic event reporting system:

- Nurse reports: Attempted to page Dr. ___ about one of his patients, 56 y/o with progressive renal failure and BP elevation...BPs continued to rise so I paged again and called his office...Office said they would give him a message...After 30 more min we called the RRT...shortly after the team arrived Dr. ___ shows up...clearly...declares "I will fix this problem"...Returns with a poster with his name and pager number...pulls out a roll of tape and...
For a single “event”…

Informal Conversation Espresso
(see handouts for each)
Addressing Behaviors that Undermine Safety Culture

Principles for Espresso Conversations

- As your leader...let you know that the behavior/action was noticed
- Documentation – but declare, “I will drop a note…”

See Handout:

Coffee Talk Practice Exercises

<table>
<thead>
<tr>
<th>Case</th>
<th>Pushback Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whistling a Tune</td>
<td>Surprised &amp; Dismissive</td>
</tr>
<tr>
<td>Scrub the Hub: let it ride</td>
<td>Disengaged, mostly silent</td>
</tr>
<tr>
<td>Those are my Crackers</td>
<td>Narcissistic, Arrogant</td>
</tr>
<tr>
<td>Standing Around</td>
<td>Angry, Waste of Time</td>
</tr>
<tr>
<td>Third Time Out Report</td>
<td>System is so Dysfunctional</td>
</tr>
<tr>
<td>Shift Report</td>
<td>Had to get home, Family issues</td>
</tr>
<tr>
<td>Hand Washing</td>
<td>Others do worse than me</td>
</tr>
<tr>
<td>Cell Phone</td>
<td>Acknowledge event, no big deal</td>
</tr>
</tbody>
</table>
I'm only one person…

*What can I do?*

- Model professionalism
- Self-reflect on your own behavior
- Speak up or report when you see/experience lapses in professionalism
- Commit to engage others in building a culture of accountability
- Discuss what you’ve learned with your leader

I'm a Leader…

*What should I do?*

- Everything on the previous slide, plus
- Review your Gap Analysis
- Write down three things that will move you closer to your goal
  - Complete
  - Repeat
Takeaways from this Session

1. Cup of Coffee Handout
2. Espresso Handout
3. Gap Analysis

Now or Later

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