A Comprehensive Framework for Patient Safety

Allan Frankel, MD and Carol Haraden, PhD

8 October 2015
A Framework for a System of Safety Objectives

1. Link safety to organizational strategy and resources
2. Define a culture of safety
3. Apply improvement methods through applied human factors and reliability science
4. Differentiate continuous learning systems (at organization and unit levels)
5. Describe patient safety governance
6. Link patient safety and patient centeredness
Exercise

- You are assigned responsibility to evaluate a unit in a healthcare organization.
  
  \textit{(Unit = Department, Division, Section – a delineated group working together)}

- The unit is new to you.

- You are to evaluate the unit for its ability to achieve safe, reliable, patient-centered operational excellence.

- What will you assess?
A Familiar Framework

**Personal Habits**
1. Risk Factors
2. Exercise
3. Nutrition
4. Health Literacy
5. Etc

**Physical Exam**
1. Cardiovascular
2. Pulmonary
3. Gastrointestinal
4. Musculoskeletal
5. Etc
Learning System

A learning system collects and analyzes social, clinical and operation metrics based on a strategic plan; engages multidisciplinary teams to debrief and put into action processes (PDSA) to improve the outcomes and incorporate a continuous feedback loop to reassess if the new processes have generated better social, clinical and operational outcomes.

Culture

“...the product of the individual and group values, attitudes, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety programs.”
Framework for Clinical Excellence

Patient Safety

- Improving work processes and patient outcomes using standard improvement tools including measurements over time.
- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.
- Facilitating and mentoring teamwork, improvement, respect and psychological safety.
- Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations.
- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.
- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.
- Regularly collecting and learning from defects and successes.
- Gaining genuine agreement on matters of importance to team members, patients and families.
- Being held to act in a safe and respectful manner given the training and support to do so.

© IHI and Allan Frankel
Patient and Family Centered Care

- An organizational goal
- Patient and family knowledge, value, beliefs and cultural backgrounds are incorporated into care planning and decision-making
- Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation, facility design, professional education and care delivery
- Open discussion of adverse events is supported and expected
A Safety Framework – 9 Components

- **Leadership** – facilitate and mentor teamwork, improvement, respect and psychological safety
- **Teams** – agree upon specific behaviors
- **Communication** – transmission and reception of information is one and the same
- **Accountability** – supports psychological safety because employees believe that they’ll be treated fairly
- **Psychological Safety** – speaking up is safe to do
- **Continuous learning** – generate reliable care by applying best evidence and minimizing variation
- **Reliable care** – continuous and owned by the frontline
- **Improvement and measurement** – generate quality, mitigates and eliminates defects
- **Transparency** – continuous learning is visible
Culture Components

- Leadership – facilitate and mentor teamwork, improvement, respect and psychological safety
- Teams – agree upon specific behaviors
- Communication – transmission and reception of information is one and the same
- Accountability – supports psychological safety because employees believe that they’ll be treated fairly
- Psychological Safety – speaking up is safe to do
Leadership

- Guardians of the Learning System
- Ensure psychological safety
  - Approachable
- Competent
Psychological Safety

- Image Protection
  - Stupid
    - Don’t ask questions
  - Incompetent
    - Don’t request feedback
  - Negative
    - Don’t criticize
  - Disruptive
    - Don’t make suggestions

Attribution: Amy Edmondson
Teamwork

- Plan forward
- Reflect back
- Resolve conflict

Use of:
- Briefing
- Debriefing
- Critical language
Briefing

- Goal and game plan
- Psychological safety
- Norms of conduct
  - Attitudes
  - Behaviors
- Expectations of excellence
Debriefing

- What worked well?
- What didn’t?
- What should we differently next time?
Communication

- Communicate clearly
  - SBAR
  - Closed loop communication
Just Culture

- You can’t be malicious
- You can’t have you sensorium impaired
- You can’t be reckless

- Would 3 others with similar skills in the similar situation do the same?

- Do you have a history of unsafe acts?

Attribution: James Reason and David Marx
Learning System Components

- Continuous learning – generate reliable care by applying best evidence and minimizing variation
- Reliable care – continuous and owned by the frontline
- Improvement and measurement – generate quality, mitigates and eliminates defects
- Transparency – continuous learning is visible

Patient and Family Centered Care
Continuous Learning System

Ensure Feedback ➔ Collect Information

Assign Accountability ➔ Analyze it

Identify Actions ➔
An improvement method

- Driver Diagrams
  - Set Aims
  - Link Strategy to Tactics (Objectives to Action)

- PDSAs
  - What are we trying to accomplish?
  - What change are we making?
  - How will we know the change is an improvement?

- Deployment plan
  - Testing, Implementation, Spread
A learning system collects and analyzes social, clinical and operation metrics based on a strategic plan; engages multidisciplinary teams to debrief and put into action processes (PDSA) to improve the outcomes and incorporate a continuous feedback loop to reassess if the new processes has generated better social, clinical and operational outcomes.

“...the product of the individual and group values, attitudes, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety programs.”
Framework for Clinical Excellence

Patient Safety

- Improving work processes and patient outcomes using standard improvement tools including measurements over time.
- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.
- Facilitating and mentoring teamwork, improvement, respect and psychological safety.
- Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations.
- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.
- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.
- Regularly collecting and learning from defects and successes.
- Gaining genuine agreement on matters of importance to team members, patients and families.
- Being held to act in a safe and respectful manner given the training and support to do so.
<table>
<thead>
<tr>
<th>Key Change Ideas</th>
<th>What will I do in...</th>
<th>30 days? (low resources, rapid approval, low barrier to entry)</th>
<th>6 months? (Minimal resources, supervisor approval, medium barrier to entry)</th>
<th>1-2 years? (Organizational change, high barrier to entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
<td>Yearly safety goals are set and include mortality, adverse events and reliable care.</td>
<td>Leaders agree to include goals.</td>
<td>Goals are set and shared throughout the organization/department. Each strategic goal/project is linked to a senior leader.</td>
</tr>
<tr>
<td><strong>Improvement and Measurement</strong></td>
<td></td>
<td>Staff measures their own processes and outcomes and uses the data to improve systems.</td>
<td>Staff introduced to the use of data for improvement.</td>
<td>Training on data collection and interpretation to use for improvement.</td>
</tr>
<tr>
<td>Key Change Ideas</td>
<td>What will I do in...</td>
<td>30 days?</td>
<td>6 months?</td>
<td>1-2 years?</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------</td>
<td>----------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Transparency</td>
<td></td>
<td>(low resources, rapid approval, low barrier to entry)</td>
<td>(Minimal resources, supervisor approval, medium barrier to entry)</td>
<td>(Organizational change, high barrier to entry)</td>
</tr>
<tr>
<td></td>
<td>Creation of a transparent and defect identification and resolution process.</td>
<td>An Improvement Board with processes, outcomes, defect identification and resolution, is tested and implemented in one unit.</td>
<td>All departments across the facility have Improvement Boards.</td>
<td>There is a process in place by which senior management uses the learning from the Improvement Boards to drive decision making.</td>
</tr>
<tr>
<td>Teamwork &amp; Communication</td>
<td>All caregivers are trained in teamwork and communication.</td>
<td>A method is selected for teaching team practice.</td>
<td>Schedule for all to be trained in teamwork practice.</td>
<td>Yearly education plan exists and incorporates team training.</td>
</tr>
<tr>
<td>Psychological Safety</td>
<td>Key Change Ideas</td>
<td>30 days?</td>
<td>6 months?</td>
<td>1-2 years?</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(low resources, rapid approval, low barrier to entry)</td>
<td>(Minimal resources, supervisor approval, medium barrier to entry)</td>
<td>(Organizational change, high barrier to entry)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Get baseline measurement of psychological safety and/or do focused interviews evaluating the level of psychological safety in the areas of interest</td>
<td>Establish feedback discussions between front line personnel and nurse managers, mostly, with discussions about safety and general concerns.</td>
<td>Have regular huddles and briefings that include psychological safety issues every day.</td>
</tr>
<tr>
<td>Key Change Ideas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negotiation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All caregivers are trained in the use of SBAR.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Select a unit and collect SBAR training materials.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train one department in the use of SBAR.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital-wide implementation in the use of SBAR for standardized communication.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A method exists to assist groups apply a fair and just accountability schema to adverse events.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Board and executive leadership agree to adopt a Just Culture model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Just Culture training begins.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Just Culture schema is applied for individuals involved in an adverse event.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous Learning</td>
<td>Key Change Ideas</td>
<td>What will I do in…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td>-------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                     | There is a standard method to learn from adverse events and close calls. | 30 days?  
(low resources, rapid approval, low barrier to entry) | Agreement is reached on developing a method to learn from adverse events and close calls. | Training in how to analyze information gathered from investigations of adverse events and close calls. | There is a process in place by which information learned from adverse events and close calls is used to improve processes to address safety issues. |
|                     | Reliability      | 6 months?  
(Minimal resources, supervisor approval, medium barrier to entry) | Training starts for improvement teams. | Reliable design is available to all staff.  
Measurement and monitoring system in place for process reliability. |
|                     | Process reliability is an expectation and reliable design principles are to be used in improvement work. | 1-2 years?  
(Organizational change, high barrier to entry) | | |
<table>
<thead>
<tr>
<th>Key Change Ideas</th>
<th>What will I do in...</th>
<th>6 months?</th>
<th>1-2 years?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30 days?</td>
<td>(Minimal resources, supervisor approval, medium barrier to entry)</td>
<td>(Organizational change, high barrier to entry)</td>
</tr>
<tr>
<td>Board level measures of safety, risk and culture are included in dashboards.</td>
<td>Discussion of selection of measures for dashboard.</td>
<td>Measures selected and prepared for dashboard.</td>
<td>Presence of a balanced scorecard that includes safety/risk matrix. Safety and Risk present together to Board.</td>
</tr>
<tr>
<td>There is a process that incorporates Board members in Leadership Walk Rounds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Message organizational values.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare practitioners listen to and honor patient and family perspectives and choices.</td>
<td>Select practitioners to develop plan to include patients.</td>
<td>Practitioners trained on interactions with patients.</td>
<td>Patients/families participate in care and decision making at the level they choose, including multidisciplinary rounds.</td>
</tr>
</tbody>
</table>
PATIENT SAFETY GOVERNANCE

- Board level measures of safety, risk and culture are included in dashboards.
- There is a process that incorporates Board members in Leadership WalkRounds.
- The Board and senior leaders message a simple set of organizational values.
- Leaders support an environment of appropriate accountability, transparency, and open disclosure.
- Leaders support and nurture a collaborative care culture based on effective teamwork.
The Safety Framework
- The elements in a system of safety

Driver Diagram
- Relates improvement aim to actions

Execution Strategy
- How do you take an aim, driver diagram or a strategy and make it work!
Take a moment to reflect on your own work. What will you incorporate from this session into your plans?