Model for Improvement

Organizational Fairness / Just Culture

Michael Leonard, MD
September 9, 2012

Disclosure: I am a Principal in a company called Pascal Metrics Inc. that develops and implements safety metrics. We will disclose the commercial interests we have, and present a balanced view of the topic.

Objectives

• Understand a clear algorithm that allows your organization and frontline providers to differentiate between unsafe individuals and skilled individuals working in complex systems
• Be able to readily explain what the “rules” are and be apply them to real situations.
• Understand how to effectively apply such an algorithm within your organization.
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Perspectives on Human Error – Sidney Dekker

**Old View**
- Human error is a cause of trouble
- You need to find people’s mistakes, bad judgments and inaccurate assessments
- Complex systems are basically safe
- Unreliable, erratic humans undermine system safety
- Make systems safer by restricting the human contribution

**New View**
- Human error is a symptom of deeper system trouble
- Instead, understand how their assessments and actions made sense at the time - context
- Complex systems are basically unsafe
- Complex systems are tradeoffs between competing goals – safety v. efficiency
- People must create safety through practice at all levels

A Little Bump on the Forehead

- Seen by primary care, referred to dermatology
- Bump biopsied – dermatofibromasarcoma = bad
- Tumor read correctly
- Written report to primary care physician
- Place on his desk, help assistant places it back in the chart
- Patient lost to follow-up for 15 months.
- Little problem becomes big problem
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Little Things – Big Problem

- Room 20
- Look out the window
- A simple knee scope
- He’s OK – he’s not too sedated - you go home
- What it says on the box is not what’s in the box

Systemic Migration of Boundaries: Deviation is Normal

\[ \text{HIGH} \quad \text{Production Performance} \quad \text{LOW} \]

100\% Agreement Non-acceptable

100\% Expected safe space of action as defined by professional standards

Usual Space Of Action

‘Illegal normal’ Real Life standards 60-90\%

Safety Reg’ s & good practices, accreditation standards

Very Unsafe Space

Individual Benefits

Very Unsafe Space

Rene Amalberti, MD, PhD

Patient Safety Officer Executive Development Program
Institute for Healthcare Improvement
Model for Improvement

O-RINGS DESIGNED FOR > 55 DEGREES
LAUNCH – 36 DEGREES
NORMALIZATION OF DEVIANCE
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Case One

• A 23 y/o woman is admitted for bowel surgery related to IBD.
• Admitted to the hospital bed by the door, her roommate leaves, and she wants to move to the bed by the window.
• Nurses say yes, but forget to change it in the computer.

Case One (cont)

• They anticipate transfusing her during surgery, as she is chronically anemic.
• Someone comes at 5:00 AM the morning of surgery, doesn’t want to disturb the other patient, doesn’t turn on the light in the room and draws the type and cross on the wrong patient.
• She is transfused in the OR, wrong blood.
## The Fair Evaluation and Response Chart

**HOW TO USE THIS CHART:** This chart should be used to categorize an individual caregiver’s actions, not groups or systems. Evaluate each factor that influenced the caregiver’s actions separately. When determining accountability, consider the context in which the action occurred.

1. Choose the column that best describes the caregiver’s mindset and actions. Read down the column for definition and recommended responses.

<table>
<thead>
<tr>
<th>IMPAIRED JUDGMENT</th>
<th>MALICIOUS ACTION</th>
<th>RECKLESS ACTION</th>
<th>RISKY ACTION</th>
<th>UNINTENTIONAL ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td>The caregiver’s thinking was impaired - by illegal or legal substances - by cognitive impairment - by severe psychosocial stressors</td>
<td>The caregiver wanted to cause harm.</td>
<td>The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice. The decision appears to be self-serving and to have been made with little or no concern about risk.</td>
<td>The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.</td>
<td>The caregiver made or participated in an error while working appropriately and in the patients’ best interests.</td>
</tr>
<tr>
<td>• Discipline is warranted if illegal substances were used.</td>
<td>• Discipline and/or legal proceedings are warranted.</td>
<td>• The caregiver is accountable and needs re-training. Discipline may be warranted.</td>
<td>• The caregiver is accountable and should receive coaching.</td>
<td>• The caregiver is not accountable.</td>
</tr>
<tr>
<td>• The caregiver’s mindset and performance should be evaluated to determine whether a temporary work suspension would be helpful.</td>
<td>• The caregiver’s duties should be suspended immediately.</td>
<td>• The caregiver should participate in teaching others the lessons learned.</td>
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<td>• The caregiver should participate in investigating why the error occurred and teach others about the results of the investigation.</td>
</tr>
<tr>
<td>• Help should be actively offered to the caregiver.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

**Further evaluation of these columns will help determine next steps.** Continue below:

2. If three other caregivers with similar skills and knowledge would do the same in similar circumstances:

- The system supports reckless action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.
- The system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.
- The system supports error and requires fixing. The system’s leaders are accountable and should apply error-proofing improvements.

3. If the caregiver has a history of repeatedly making mistakes, the caregiver may be in the wrong position. Evaluation is warranted, and coaching, transfer or termination should be considered. The corrective actions above should be modified accordingly.

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## Case Two

- Box of heparin comes to the NICU, say 10 units/ml on the outside, contains 1000 U/ml vials
- Pharmacy tech is great, been there 20 years, “wouldn’t make a mistake”
- 9 people give 100 times too much heparin to very small children
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- by severe psychosocial stressors | The caregiver wanted to cause harm. | The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice. The decision appears to be self-serving and to have been made with little or no concern about risk. | The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous. | The caregiver made or participated in an error while working appropriately and in the patients’ best interests |
| • Discipline is warranted if illegal substances were used.  
• The caregiver’s mindset and performance should be evaluated to determine whether a temporary work suspension would be helpful.  
• Help should be actively offered to the caregiver. | • Discipline and/or legal proceedings are warranted.  
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Further evaluation of these columns will help determine next steps.

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Findings from the Department of Health

What Are You Going to Do?

- Do you have a workable model, and how visible is it to the people delivering care?
- How will you assess how much your algorithm lives and breathes at the bedside?
- What can you do to “make it the way we work around here?”