A Comprehensive Framework for Patient Safety

Allan Frankel, MD
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Disclosure: I am a Principal in a company called Pascal Metrics Inc. that develops and implements safety metrics. We will be discussing this topic in general and will reference many options about safety metrics, including those produced by Pascal. We will disclose the commercial interests we have, and present a balanced view of the topic.

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
A Safety Framework – 8 components

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

1. Cardiovascular
2. Pulmonary
3. Gastrointestinal
4. Musculoskeletal
5. Etc

1. Leaders who facilitate and mentor teamwork, improvement, respect and psychological safety
2. Teams who know the game plan and agree upon specific behaviors
3. Communication where transmission and reception of information is one and the same
4. Accountability that supports psychological safety because employees believe that they'll be treated fairly

1. A Continuous Learning Process that generates reliable care by applying best evidence and monitoring variation
2. Reliable Care Processes continuously, owned by frontline providers
3. Applies Formal Improvement Methods and Measurement to generate quality and mitigate and eliminate defects
4. Transparency where the learning efforts are known to all and discussed as a daily part of work
A Safety Framework – 8 Components

1. Leaders
   who facilitate and mentor teamwork, improvement, respect and psychological safety

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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

  — Brief
  — Debrief
  — Critical language
Briefing

- Goal and Game Plan
- Psychological Safety
- Norms of Conduct
  - Attitudes
  - Behaviors
- Expectations of Excellence

Debrief

- 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
A Safety Framework – 8 Components

1. A Continuous Learning Process
   that generates reliable care by applying best evidence and minimizing variation

2. Reliable Care Processes
   continuously, owned by frontline providers

3. Applies Formal Improvement
   Methods and Measurement
to generate quality and mitigate and eliminate defects

4. Transparency
   where the learning efforts are known to all and discussed as a daily part of work

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

Reference Material
TO ACHIEVE SAFE AND RELIABLE CARE:

**PATIENT CENTEREDNESS**

- Patient and family centered care is an organizational goal.
- Patient and family knowledge, values, 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; in facility design; and in professional education as well as in the delivery of care.
- Open discussion of adverse events is supported and expected.

**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?