Michigan Critical Access Hospital Quality Network

Strategy Group #1 Making Care Safer

As a premier system of quality, the Michigan Critical Access Hospital Quality Network (MICAH QN) will be a model in developing processes that demonstrate the high quality service provided by CAHs. MICAH QN will identify opportunities for change that lead to continued improvement in the health status of the population we serve.

Objectives

- Bring together MI CAHs to reflect and learn with each other
- Understand and reflect on own organizations safety culture
- Understand opportunities to enhance safety culture

Ground Rules

- Case presented from CMS Statement of Deficiencies and Plan of Corrections Report.
- You might disagree with aspects of the case/findings, and that’s okay, but we will not debate today.
- Our purpose is to learn by assess all events (our own and others) to identify ways to improve care.

Plan

- Overview of Safety: Fair and Just Culture – 10 minutes
- Swiss Cheese Model and Overview of Fatal Medication Error – 15 minutes
- Small Group Breakouts: Identify system failures – 15 minutes
- Large Group Report Out on System Failures – 5 minutes
- Small Group Breakouts: What can WE do to prevent these system failures – 15 minutes
- Large Group Report Out: 5 minutes
- Post Meeting: Resource Document

Safety: Fair and Just Culture

MAY 20, 2022

BARB WAINRIGHT, LEAD IMPROVEMENT SPECIALIST

REFERENCE: JUST CULTURE ALGORITHM V4.0 OUTCOME ENGENUITY, LLC COPY RIGHT 2014, 2019

What is a Fair and Just Culture in Healthcare?

- Organizations commitment to treat healthcare workers fairly when a patient is harmed or nearly harmed.
- Improves patient safety by empowering employees to proactively monitor the workplace and participate in safety efforts in the work environment.
- Improving patient safety reduces risk by its focus on managing human behavior and redesigning systems.
- Promotes and exhibits a quality learning environment as a responsibility to both employees and patients.
- Allows staff to feel confident to speak up when events go wrong, rather than fearing blame.

Threshold Investigation

What happened?
What normally happens?
What does procedure require? (If applicable)
Why did it happen?
How as the organization managing the risk?

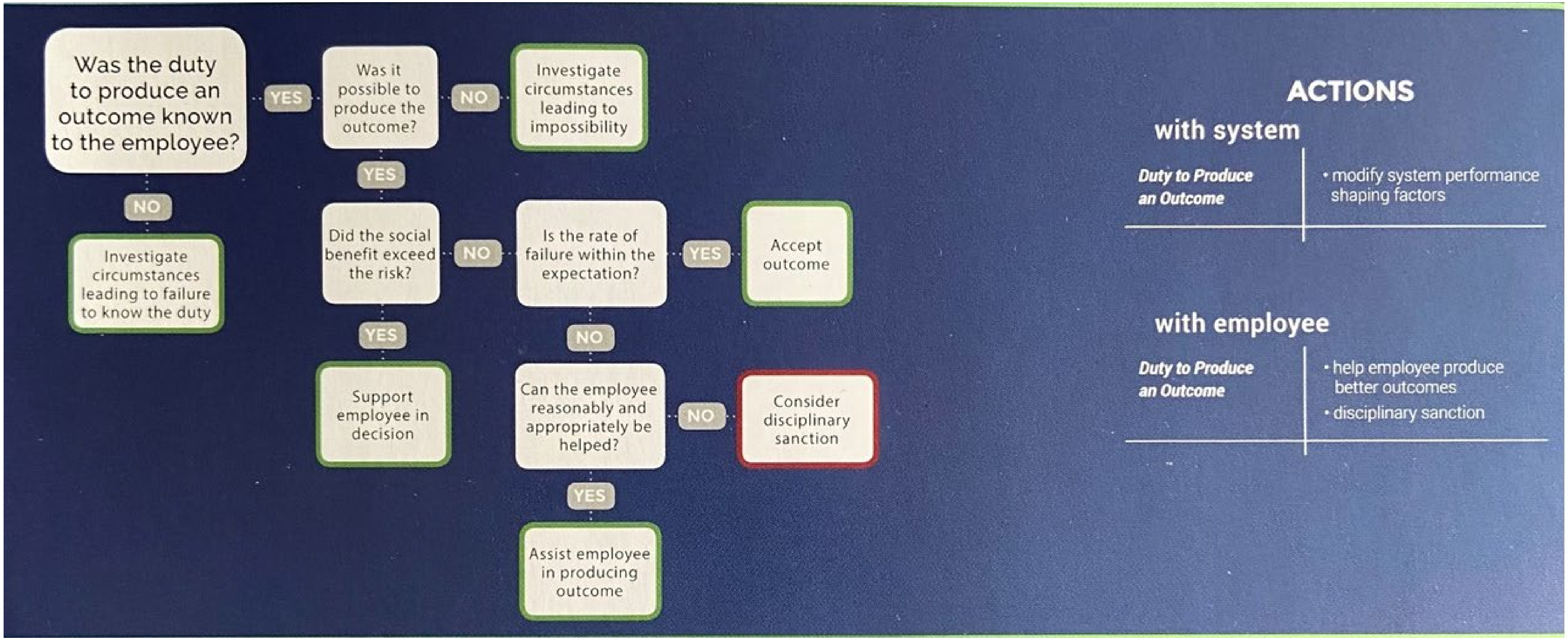
The Three Duties

Duty to Avoid Causing Unjustifiable Risk or Harm ❑ values-focused ❑ "conduct unbecoming"
Duty to Follow Procedural Rules ❑ reliability-focused ❑ "the recipe"
Duty to Produce Outcomes ❑ mission-focused ❑ "the cake"

The Five Behaviors

Human Error Unintended conduct: inadvertently doing other than what was intended : a slip, lapse, or mistake Action: Accept
AT-Risk Behavior A choice where risk is not recognized or is mistakenly believed to be justified. Action: Coach
Reckless Conscious disregard of a substantial and unjustifiable risk of harm. Action: Disciplinary Sanction
Knowledge Knowingly causing harm (sometimes justified) Action: Disciplinary Sanction
Purpose A purpose to cause harm (never justified) Action: Disciplinary Sanction

Example of Just Culture Algorithm: Duty to Produce Outcomes




Questions

Patient Safety Goal:
to assess all events (our own and others) to identify ways to improve care.

Swiss Cheese Model

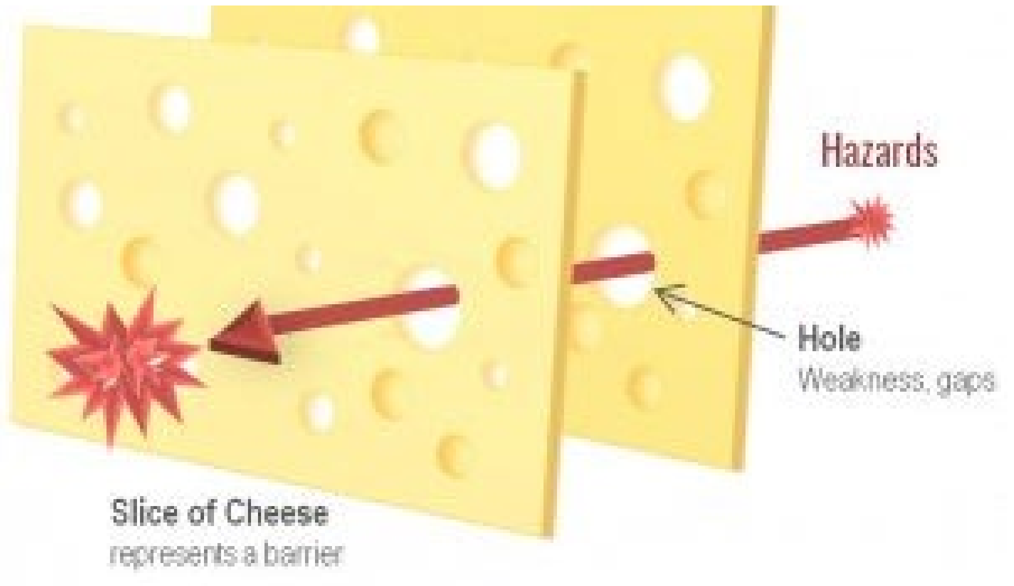
The Institute of Medicine (IOM) report To Err Is Human: Building a Safer Health System (IOM, 2000)

identified medication errors as the most common type of error in health care

estimates at least <u>1.5 million Americans are injured by medication errors every year</u>.

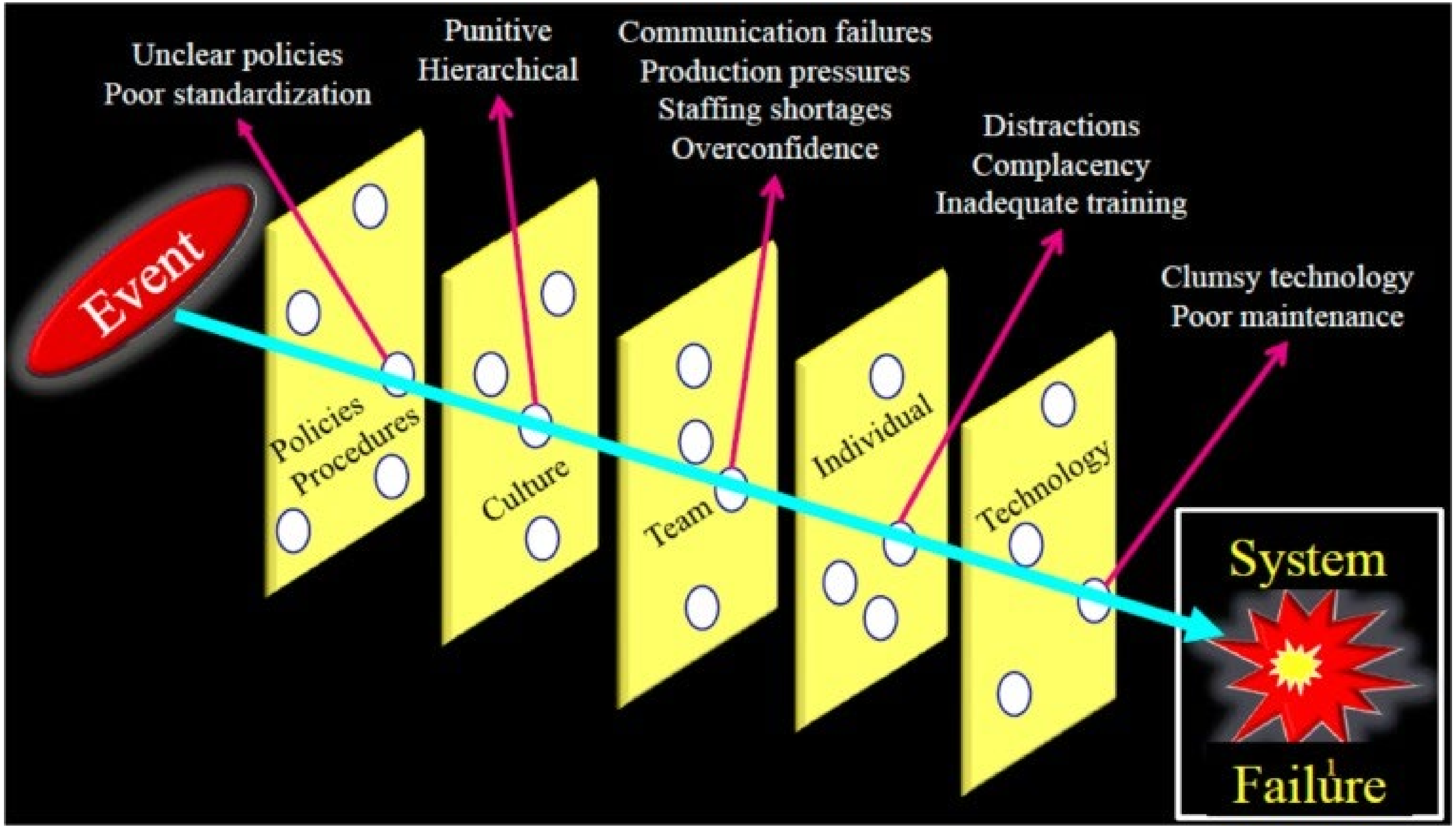
On average, <u>every hospitalized patient is subjected to at least one medication error every day</u>, and medication errors are estimated to account for over 7000 deaths in 1993.

National Library of Medicine: High Reliability Organizations—Medication Safety

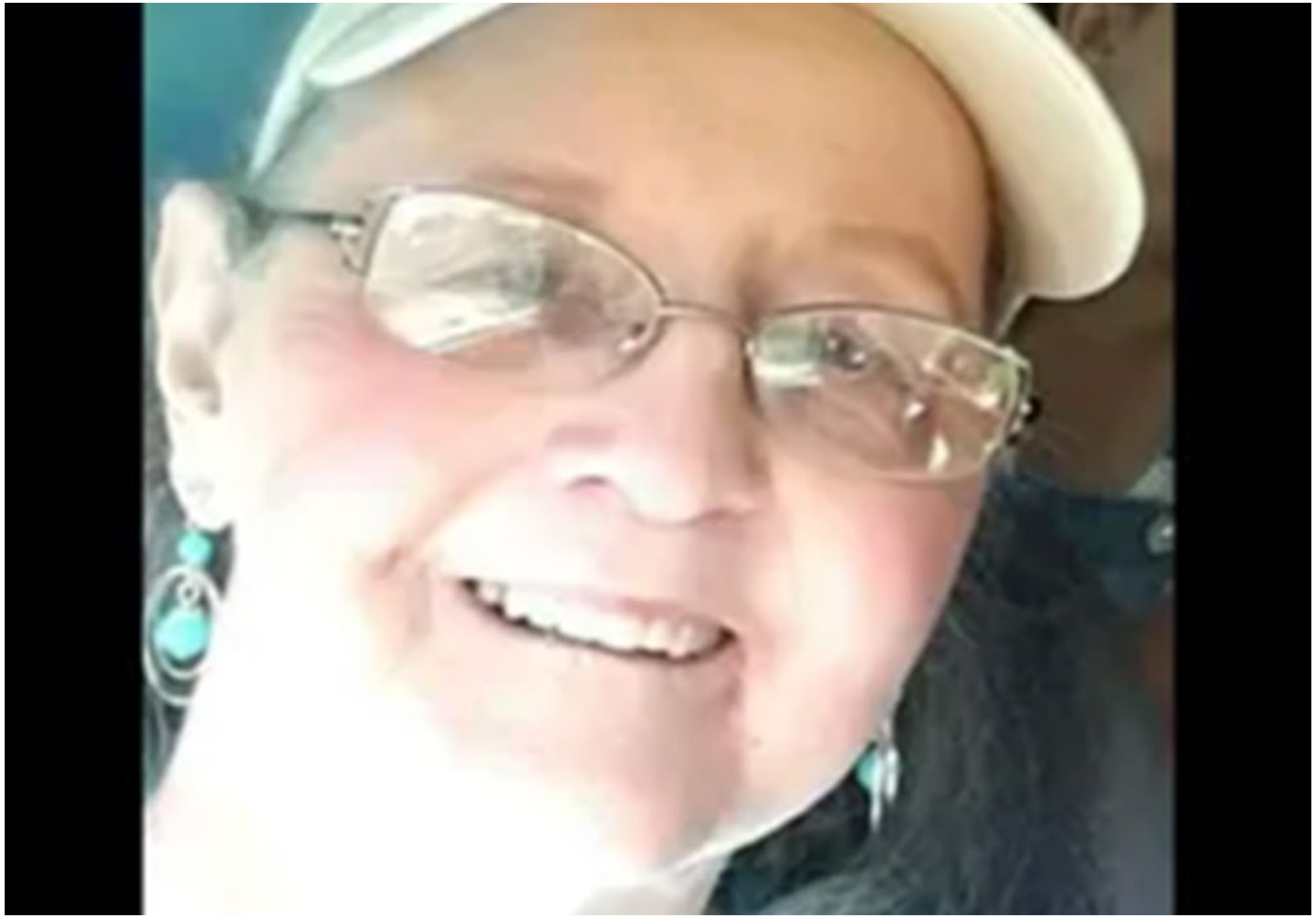


Dr. W. Edwards Deming

94 percent of variations observed in workers' performance levels have nothing to do with the workers. Instead, most of the performance variations are caused by the system, of which those people are but a part.



Fatal Medication Error



Summary of Fatal Medication Error

Source:
CMS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION VANDERBILT UNIVERSITY MEDICAL CENTER - 11/08/2018

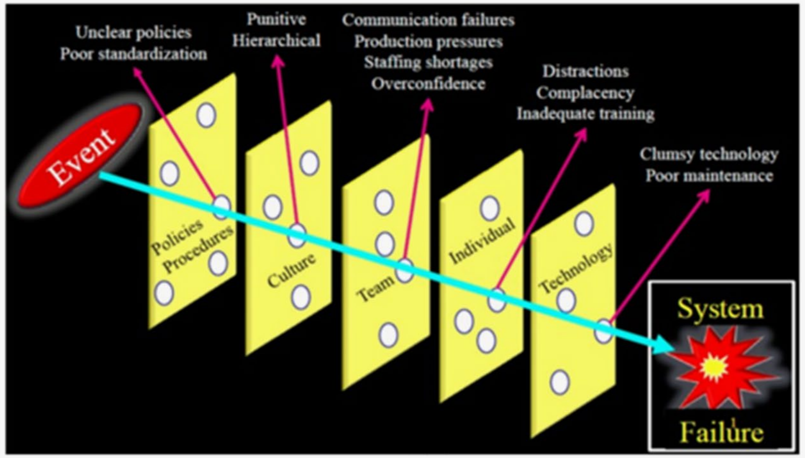
Tennessee Bureau of Investigation – State of Tennessee vs. Radonda L. Vaught CASE NO: 2019-A-76


(01) 00351662147511
(17) 210601
(21) 169893951002
(10) 061403A
See manufacturer's package insert
Distributed by HF Acquisition Co., LLC
Mukilteo, WA 98275
RX ONLY
VECURONIUM
BROMIDE
FOR INJECTION
Rx only
10 mg*
FOR INTRAVENOUS
USE ONLY
PROTECT FROM
LIGHT
*1 mg/mL when
reconstituted to 10 mL.
WARNING: Paralyzing Agent
600 × 900


NDC 0641-6056-01
Midazolam
Injection, USP
10 mg/10 mL
(1 mg/mL)
10 mL

Small Group Work

Identify
<u>SYSTEM FAILURES</u>
with this medication error



List of Holes in the Swiss Cheese

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________

Dr. W. Edwards Deming

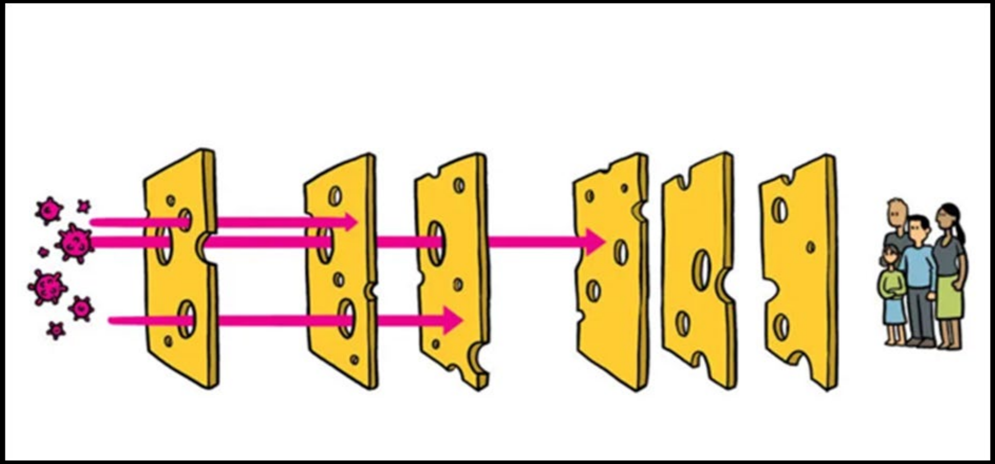
People can't perform better than the system allows

The most effective way to improve and avoid these problems is not to blame others or even yourself, but to improve the system.

Learn From Each Other

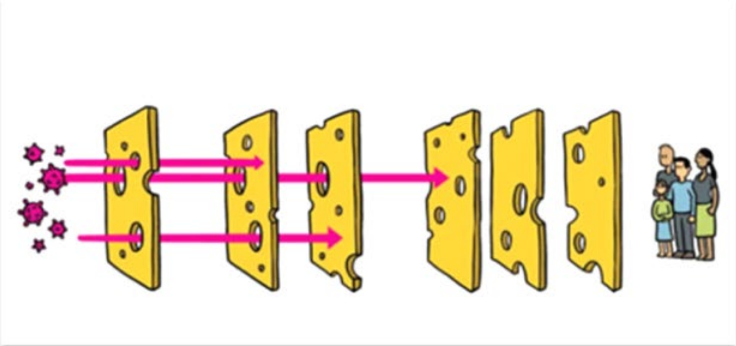
WHAT ARE THE HOLES?

CLOSING THE HOLES



Small Group Work

What can hospitals do to prevent a like event?



List how we can CLOSE The Holes in the Swiss Cheese

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

Learn From Each Other

HOW ARE WE CLOSING THE HOLES?

Dr. W. Edwards Deming

People can’t perform better than the system allows

The most effective way to improve and avoid these problems is not to blame others or even yourself, but to improve the system.

Resources and Tools for you:

- The Institute of Medicine (IOM) report To Err Is Human: Building a Safer Health System (IOM, 2000)
- The Deming Philosophy, known as Dr. Deming's “theory of management” and later his “System of Profound Knowledge,”
- CMS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION VANDERBILT UNIVERSITY MEDICAL CENTER - 11/08/2018
- Tennessee Bureau of Investigation – CASE NO: 2019-A-76
- **Crystal will share with you the list of todays System Failures and identified ways to Prevent Failures.**