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.
• 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
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.
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<th>Question</th>
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<td>What happened?</td>
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<td>What normally happens?</td>
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<td>What does procedure require? (If applicable)</td>
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<td>Why did it happen?</td>
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<td>How as the organization managing the risk?</td>
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<td>Duty to Avoid Causing Unjustifiable Risk or Harm</td>
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<th>Duty to Follow Procedural Rules</th>
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<th>Duty to Produce Outcomes</th>
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### 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
Patient Safety Goal: to assess all events (our own and others) to identify ways to improve care.
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 1.5 million Americans are injured by medication errors every year. On average, every hospitalized patient is subjected to at least one medication error every day, and medication errors are estimated to account for over 7000 deaths in 1993.
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

Small Group Work

Identify SYSTEM FAILURES with this medication error

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.
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
- Crystal will share with you the list of today's System Failures and identified ways to Prevent Failures.