Situational Monitoring

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Analyzing, Educating and Collaborating for Patient Safety

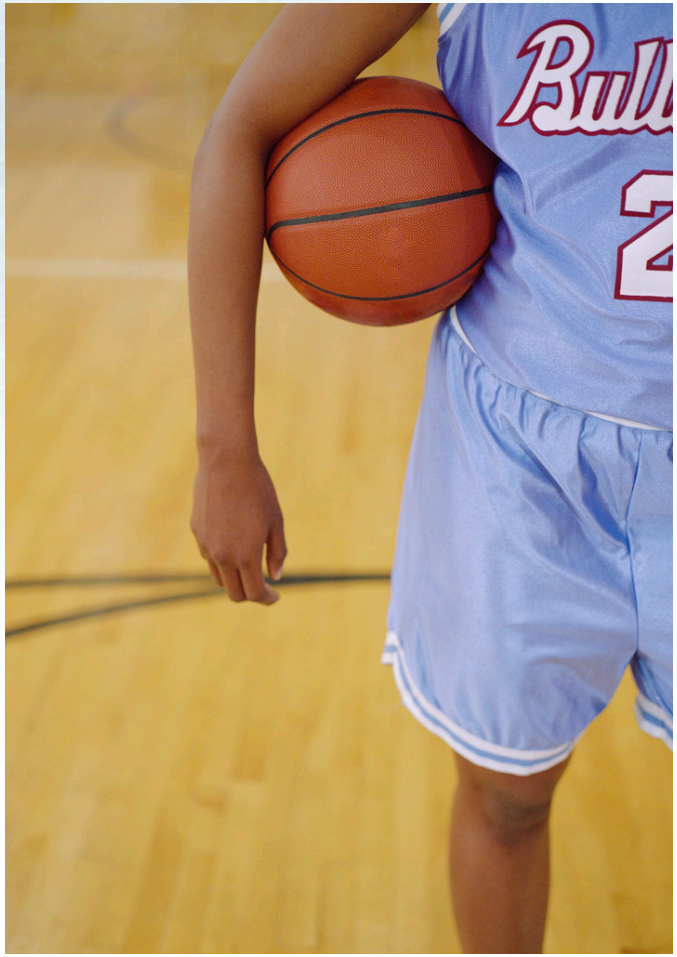
Culture / Teams Abound

What is a Fair and Just Culture?

- It's about system design and behavioral choices
- Should not be confused with "punitive" or "blame free" environments
- It's balancing system and personal accountability
- **Not severity biased**

TEST !!!

- Count
- White shirt to white shirt
- Have you played before ….shhhh
- Gender difference
- READY!



Whac-A-Mole

Punitive Culture

Blaming others—WHO? ME?

- Who made the error?
- Who dropped the ball?
- Creates fear
- Destroys creativity
- Builds barriers

How do we handle significant events as a Nation?

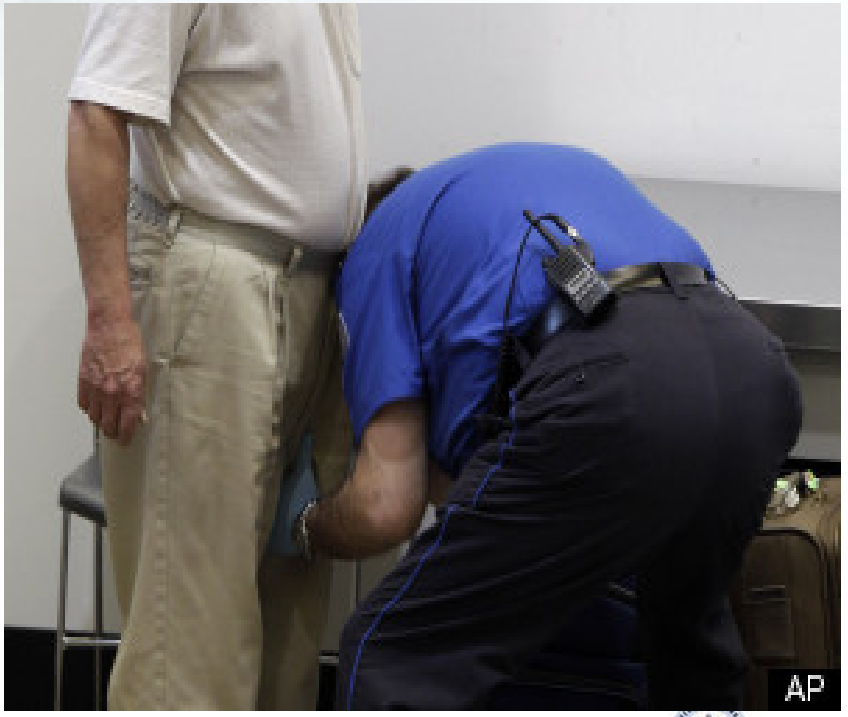
BP Oil Spill

Tony Hayward

Christmas Bomber

Christmas Bomber

Body Scanners and “Pat Downs”



Blaming

The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

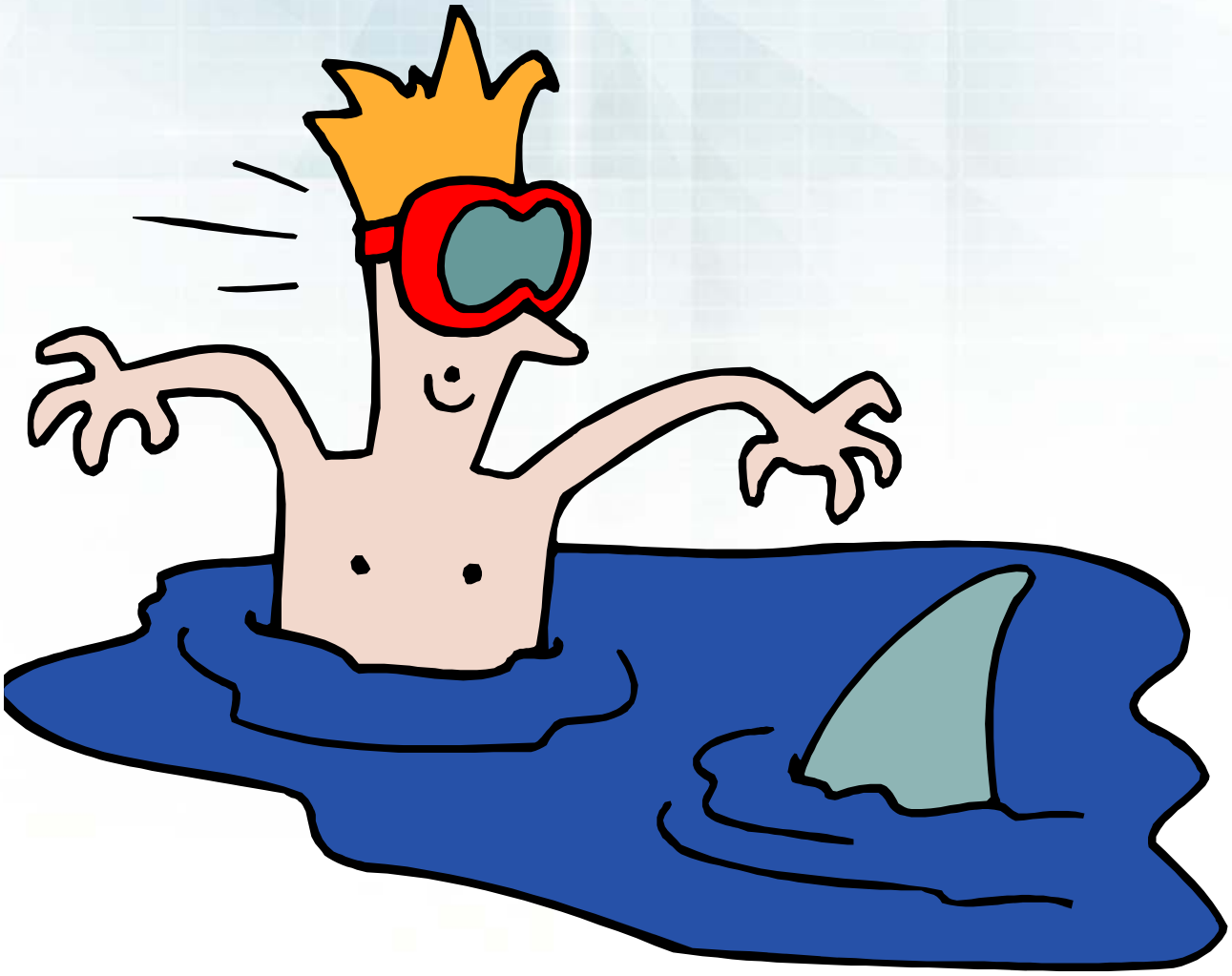
Reference: Dr. Lucian Leape, Professor, Harvard School of Public Health *Testimony before Congress on Health Care Quality Improvement*

Punitive Culture

Error is driven underground

Risk Management 101

But really in Fran's World



What is underneath can kill you

Blame Free

- Convince ourselves that no one should be accountable

Fair Culture

- To err is human
- To drift is human
- Risk is everywhere
- We must manage in support of our values
- We are all accountable

Fair Culture = behavioral choices



Human Fallibility

“To Err is Human”

Friday Morning ….

To Drift is Human

Reckless and Endangering

Hand washing

Did you know?

- According to the World Health Organization (WHO) Guidelines on Hand Hygiene in Health Care
  - In 2834 observed opportunities for hand hygiene, average adherence was 48%
  - Non-adherence was higher in ICUs compared with internal medicine, during procedures that carried a high risk of bacterial contamination, and when intensity of patient care was high
  - The lowest adherence rate (36%) was found in ICUs

http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf

WHY?

We are all accountable

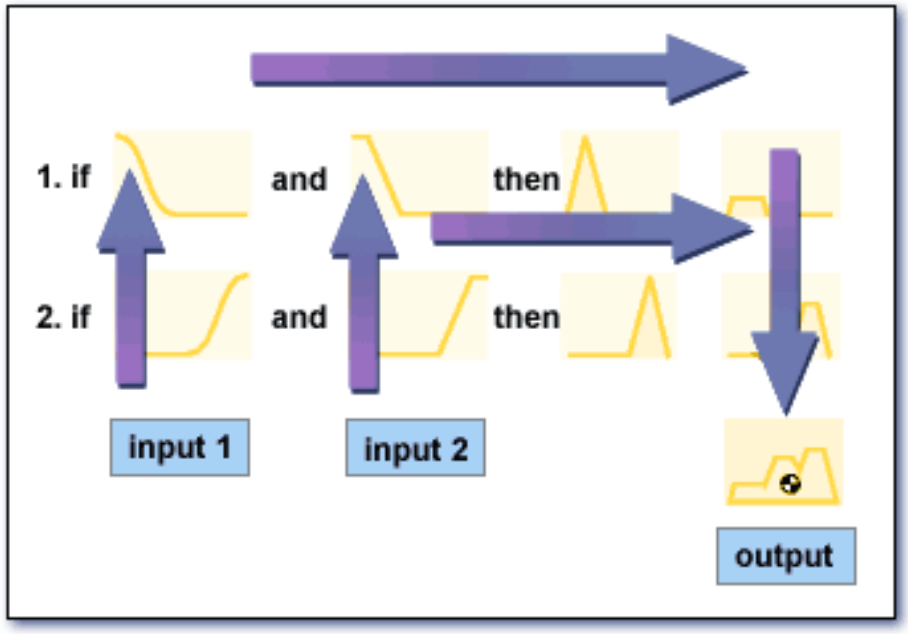
We are all accountable…..

We must manage in support of our values

- As Leaders
  - Manage system designs
  - Employee behaviors

Systems

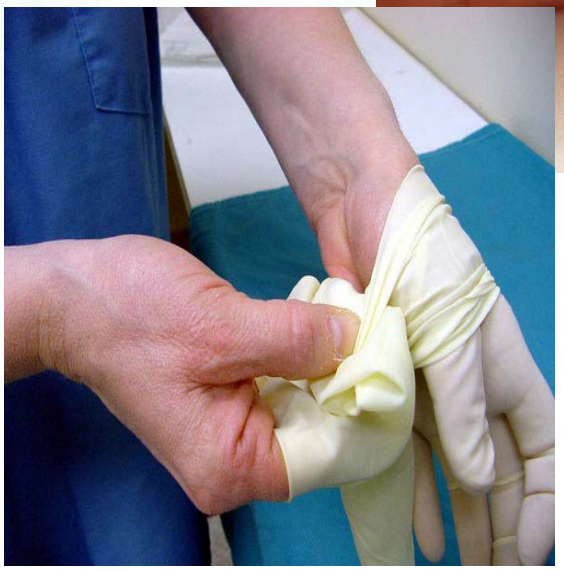
- Every system is perfectly designed to achieve exactly the results it gets



Interpreting the Fuzzy Inference Diagram

Reference: Don Berwick, MD, MPP, President and CEO, Institute for Healthcare Improvement

Do system designs ever change?

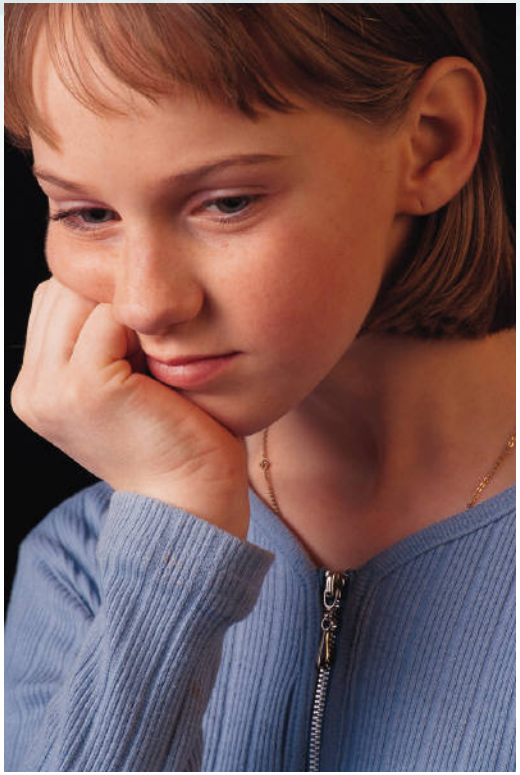


Are all advances good?

Pay ATTENTION !!

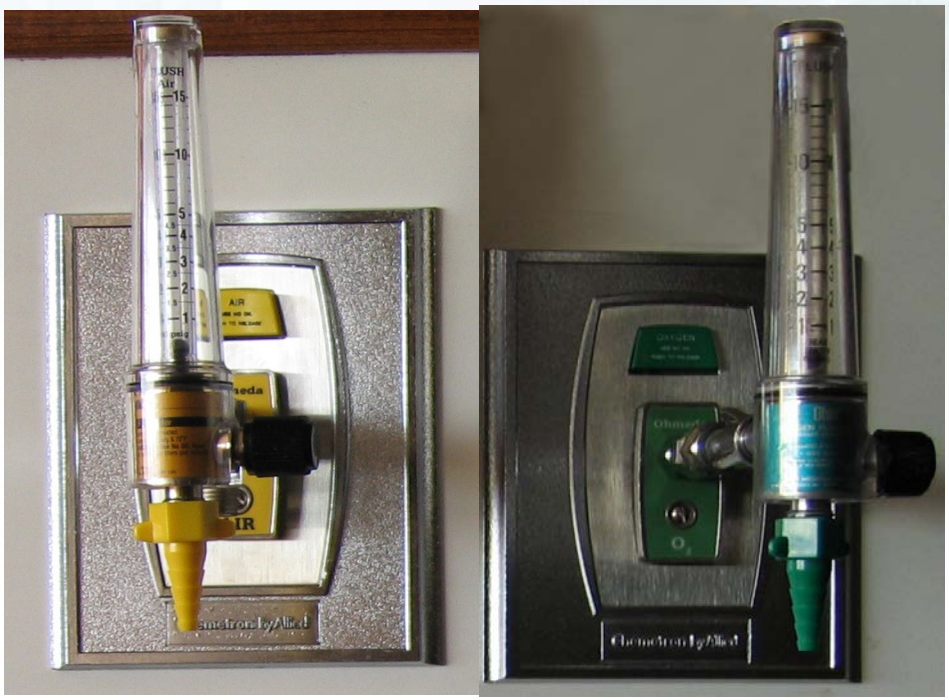
What is this regulator used for ?

Suggestions for change(s)



WEAK vs. STRONGER

WEAK



STRONG

If it needs a sign….

Never my child….

Highly Reliable Design

- Barriers

- Redundancy

- Recovery

Human performance strategies

- Make no mistakes
- Knowledge and skill
- Performance shaping factors
- Perception of risk

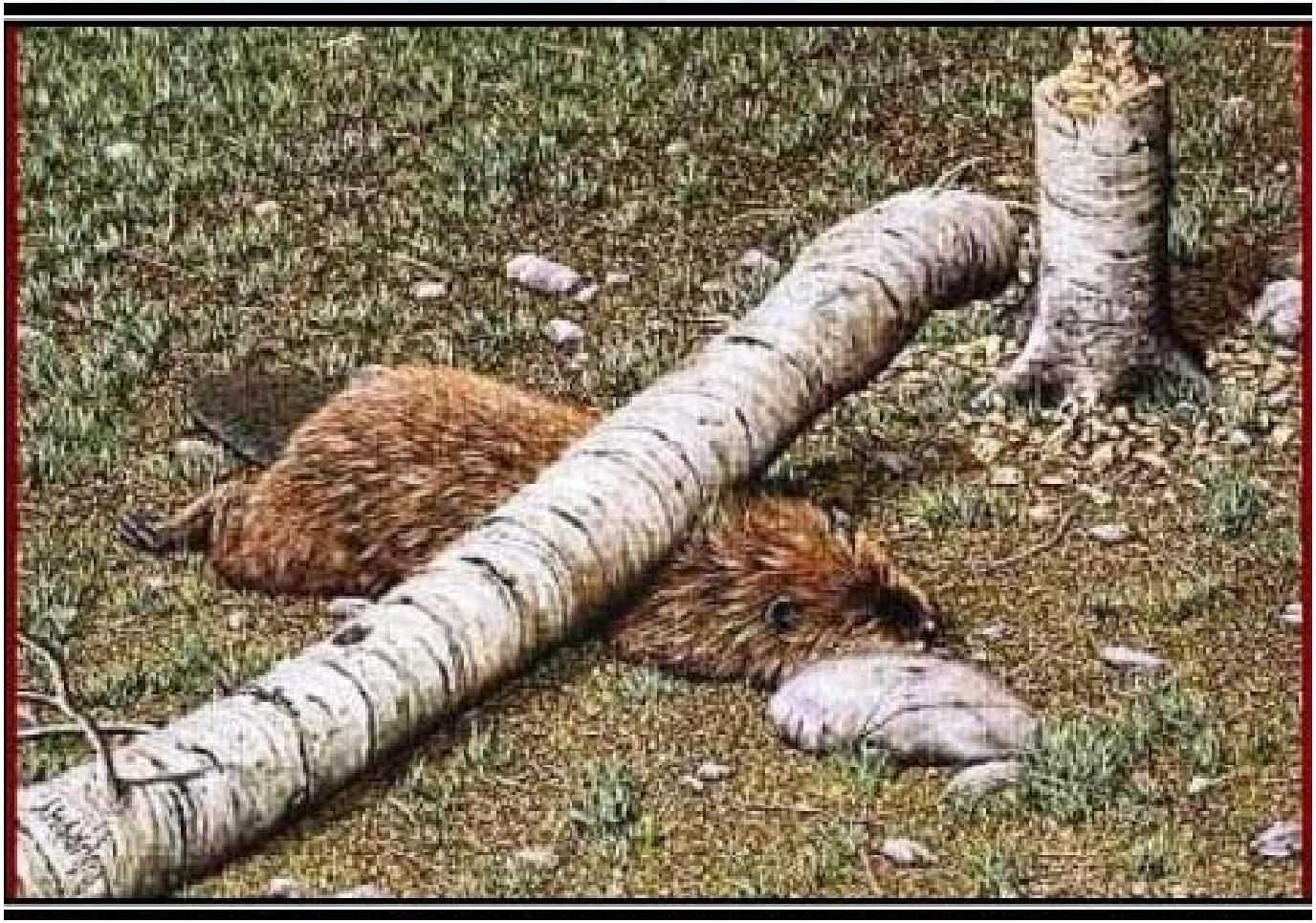
Pop ups are they working?

Workarounds

Workarounds

Workarounds

If you do not address workarounds….



And do not forget

Remember that…….

"It's not about the broken window. It's about the choice you made in playing ball in the front yard. The stakes we're talking about (in healthcare) are much higher, but the message is the same."

David Marx

Paper Airplane – A Lesson for Flying Outside of the Box

Culture is a journey ….

Questions?

References

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Thank You

www.patientsafetyauthority.org