Patient Safety Culture Bundle for CEOs & Senior Leaders

Presenters: Chris Power, Polly Stevens, Alex Munter, Linda Hughes
Patient Safety Culture Bundle for CEOs & Senior Leaders

National Health Leadership Conference
June 4th, 2018

Chris Power
CEO, CPSI
Disclosure

The Canadian Patient Safety Institute would like to acknowledge funding support from Health Canada. The views expressed here do not necessarily represent the views of Health Canada.
Background – National Patient Safety Consortium
Background (cont)

• Within the education thematic area there was a recognition of the critical role senior leadership plays in ensuring patient safety is an organizational priority.

• Working group of partners, co-led by Canadian College of Health Leaders and HealthCareCAN, brought together to advance work in this area
The Patient Safety Call to Action

• 1 death per 100 admissions (Canadian Adverse Events Study, 2004)
• In 2014, 1 in 18 hospital stays in Canada involved at least 1 harmful event - 138,000 out of 2.5 million hospital stays (CIHI, 2016)
• 15% of healthcare costs; $2.75 billion/year (Risk Analytica, 2017)
The Inspiration

“The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities”.

“Even though tools for developing a safety culture are available, a common set of best practices is needed. One can envision the development of a ‘culture bundle’, analogous to the bundle of interventions that drastically reduced ventilator associated pneumonia.”

- Free From Harm, 2015
The Challenge

“Patient safety culture is a complex phenomenon that is not clearly understood by hospital leaders, thus making it difficult to operationalize.”

- Sammer, 2010
Shift to Safety

**Patients and their families** shift to advocate for their healthcare safety.

**Healthcare** providers shift to prioritize safety when caring for patients.

**Leaders** in healthcare organizations shift to create a positive patient safety culture.
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Polly Stevens
VP, Healthcare Risk Management
Healthcare Insurance Reciprocal of Canada (HIROC)
• HIROC is owned and governed by:
  – Healthcare organizations
    • Employees, volunteers, boards, MDs in leadership
  – Midwives; regulatory colleges; national associations
• We are not-for-profit
  – Surplus funds go back into healthcare
• We are passionate about patient safety

• We promote evidence-informed management
Definitions

Patient Safety Culture
An integrated pattern of individual and organizational behavior, based on shared beliefs and values that continuously seeks to minimize patient harm, which may result for the processes of care delivery. (Kizer, 1999)

Bundle
A set of evidence-based practices that must all be applied in order to reliably deliver good care. (IHI)
Who is the leading authority on culture in healthcare?

G. Ross Baker, PhD
University of Toronto

Sara Singer, PhD
Harvard
“We have argued that **piecemeal initiatives are inadequate** and that strengthening safety culture necessitates **interventions that simultaneously (1) enable, (2) enact and (3) elaborate (learn)** it in a way that is attuned to the existing culture. This approach may hold the key to demonstrably reducing hospital (healthcare) errors and ultimately saving lives.”

Singer & Vogus, 2013
42 key resources

1. What do senior leaders need to *know* to improve safety?

2. What do senior leaders need to *do* to improve safety?
Key concepts

- Safety science
- Implementation science
- Just culture
- Psychological safety
- Staff safety/health
- Patient & family engagement
- Disruptive behaviour
- High reliability organizations/resilience
- Patient safety measurement (e.g. Vincent)
- Frontline / distributed leadership
- Physician leadership
- Staff engagement
- Teamwork / communication
- Industry-wide alignment
# The Safety Culture 13-part frame

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<tr>
<th>Enabling</th>
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The Safety Culture – Patient/Family focus

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Patient Safety Culture “Bundle” for CEO/s Senior Leaders

1. Enabling
Organizational priority
- Vision: passionate, engaged, accountable; prioritizes patient safety?
- Safety/quality vision, strategy, plan, goals (with input from patients, families, staff, physicians)?
- Safety/usability resources/infrastructure?
CEOs/senior leadership behaviors
- Relevant communication about safety/quality visions, stories, results?
- Regularly review with care settings/units, staff, physicians, patients and families?
- Model safety behaviors (e.g. honest, fairness, transparency, openness, learning, respect, humanity, inclusiveness, person-centeredness)

Human resources
- Leaders/staff/physicians engage, exceed expectations/incentives for safety/quality
- “Just culture” programs/protocols
- Disruptive behavior protocols
- Staff and physician safety (physical/psychological/burnout); safe environment program?

Health information/technology/devices
- EHR: records support safety (e.g. decision support, alerts, monitoring)?
- Technologies/devices support safety (e.g. human factors, transparency)?

Healthcare system alignment
- Community/industry-wide collaborations?
- Align with national/international standards (e.g. accreditations, regulatory, professional, industry)?

2. Enacting
- Frontline actions that improve patient safety
- Care settings and managers
- Integrated, unit-based safety practices e.g. daily briefings, visual management, local problem solving?
- Monitoring/evaluating leaders foster psychological safety (speaking up)?
- Care processes
- Standardized work/processes where appropriate?
- Communication/patient hand-off processes e.g. between shifts/units, across care continuum?
- Patient and family engagement/co-production of care
- Patients/families/patients in all aspects of care e.g. planning, decision-making, family presence policy, rounds, access to health record/visit results?
- Patients/families involved in local safety/quality initiatives?

3. Learning
- Learning practices that reinforce safe behaviors
- Education/capability building
- Leaders/staff/physicians trained in safety and improvement science, teamwork, communication?
- Team-based training, drills?
- Incident reporting/management/analysis
- Effective risk/incident reporting system for events related to patients/families and staff/physicians e.g. new behaviors, near events, morality/morbidity reviewed?
- Structured process for responding to and learning from safety events/critical incidents e.g. systems analysis, patient/family/staff physicians involvement and support?
- Safety/quality measurement/reporting
- Regular measurement of safety culture; patient/family complaints; and staff/physicians engagement by unit/setting and organization?
- Retrospective/prospective safety and quality process and outcome measures?
- Regular, transparent reporting of safety/quality plan results?
- Operational improvements
- Structured methods, infrastructure to improve reliability, streamline operations e.g. FOGA, lean, human factors engineering, prospective risk analysis?

A Framework for Establishing a Patient Safety Culture

http://www.patientsafetyinstitute.ca/en/About/Programs/shift-to-safety/Pages/default.aspx

Patient Safety Culture "Bundle" for CEOs/Senior Leaders

What is the Patient Safety Culture "Bundle"?

Strengthening a safety culture necessitates interventions that simultaneously enable, enact and elaborate in a way that is attuned to the existing culture. Through a literature review of more than 60 resources, a Patient Safety Culture Bundle has been created and validated through interviews with Canadian thought leaders. The Bundle is based on a set of evidence-based practices that must all be applied in order to deliver good care. All components are required to improve the patient safety culture.
# Patient Safety Culture “Bundle” for CEO's/Senior Leaders

## 1. Enabling

*Organizational priority setting, leadership practices that motivate the pursuit of safety*

- **Organizational priority**
  - Board educated, engaged, accountable, prioritizes patient safety?
  - Safety/quality vision, strategy, plan, goals (with input from patients, families, staff, physicians)?
  - Safety/quality resources/infrastructure?

- **CEO/senior leadership behaviours**
  - Relentless communication about safety/quality vision, stories, results?
  - Regular/daily interaction with care settings/units, staff, physicians, patients and families?
  - Model key values (e.g. honesty, fairness, transparency, openness, learning, respect, humanity, inclusiveness, person-centredness)?

- **Human resources**
  - Leaders/staff/physicians engaged, clear expectations/incentives for safety/quality?
  - "Just culture" program/protocol?
  - Disruptive behaviour protocol?
  - Staff and physician safety (physical/psychological/burnout); safe environment program?

## 2. Enacting

*Frontline actions that improve patient safety*

- **Care settings and managers**
  - Integrated, unit/setting-based safety practices (e.g. daily briefings, visual management, local problem solving)?
  - Managers/physician leaders foster psychological safety (speaking up)?

- **Care processes**
  - Standardized work/care processes where appropriate?
  - Communication/patient hand-off protocols (e.g. between shifts/units, across care continuum)?

- **Patient and family engagement/co-production of care**
  - Patients/families partners in all aspects of care (e.g. planning, decision-making, family presence policy, rounds, access to health record/test results)?
  - Patients/families involved in local safety/quality initiatives?
  - Disclosure and apology protocols?

- **Situational awareness/resilience**
  - Processes for real-time/early detection of safety risks and patient deterioration (by staff/patients/families/physicians)?

## 3. Learning

*Learning practices that reinforce safe behaviours*

- **Education/capability building**
  - Leaders/staff/physicians trained in safety and improvement science, teamwork, communication?
  - Team-based training, drills?

- **Incident reporting/management/analysis**
  - Effective risk/incident reporting system for events related to patients/families and staff/physicians (e.g. near misses, adverse events, mortality/morbidity reviews)?
  - Structured processes for responding to and learning from safety events/critical incidents (e.g. systems analysis, patient/family/staff/physician involvement and support)?

- **Safety/quality measurement/reporting**
  - Regular measurement of safety culture; patient/family complaints; and staff/physician engagement (by unit/setting and organization)?
  - Retrospective/prospective safety and quality process and outcome measures?
  - Regular, transparent reporting of safety/quality plan results?

- **Operational improvements**
Patient Safety Culture “Bundle” for CEO’s/Senior Leaders

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Learning practices that reinforce safe behaviours

Safety First – an Organizational Commitment and Value

CHEO-OCTC Action Plan 2018-19

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<thead>
<tr>
<th>2018-19 Goals</th>
<th>Measure</th>
<th>Target</th>
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<tbody>
<tr>
<td>Safety First</td>
<td># of serious safety incidents</td>
<td>0</td>
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<tr>
<td>Reduced harm for children, youth &amp;</td>
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<tr>
<td>staff including medical staff</td>
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Leadership Behaviors – “Walking the Walk”

Code Orange: Safety First Friday
High Reliability Organization principles

1. **Preoccupation with failure (track small failures)**
2. Reluctance to simplify
3. Sensitivity to operations
4. Commitment to resilience
5. Deference to expertise
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A deviation from generally accepted performance standards (GAPS) that:

- Serious Safety Event
  Reaches the patient and results in moderate to severe harm or death

- Precursor Safety Event
  Reaches the patient and results in minimal harm or no detectable harm

- Near Miss Safety Event
  Does not reach the patient – the error is caught by a detection barrier or by chance

Risk Ranking
Risk Assessment Checklists
Risk Reference Sheets

Learning from Failures
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Safety First guides our work with partners:

Children’s Hospitals’ Solutions for Patient Safety
Every patient. Every day.
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We are changing the culture with

Old Behaviors
- Do it all
- Hide problems
- Quickly work around issues
- Reactive
- Intuition
- Info flows with difficulty
- Top down control
- Ad hoc training
- Some staff/physicians
- Short-term thinking
- Get it done – heroic

New Behaviors
- Alignment and focus
- Expose problems
- Get to root – truly improve
- Proactive with rigor
- Evidence-based decisions
- Info flows smoothly
- Local decision making
- Structured development
- Engaging all
- Long-term thinking
- Appreciation for standards and process
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CHEO works is the engine that drives Quality Improvement and Safety
(it’s HOW we identify and resolve issues and ultimately make care better)
The Daily Brief is a virtual (teleconference) huddle of organizational leaders held at the start of every day to establish situational awareness of recent, ongoing or anticipated events that impact the quality of our patient care and the safety of our patients, staff and organization. It also allows us to quickly establish leadership priority, alignment and accountability for resolving issues.
We work together with children, youth and families

Together we are making care, not just safer, but better!
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Continuously reporting continuous improvements
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Learning and building capacity for improvement

Yellow Belt Training & Certification For Leaders
Click Here to Contact OD&L

The works Pathway eLearning module
Visit the Online Learning Centre to take the course and start your journey. Click here to start now!

White Belt Training & Certification
Click here to learn more...

Brown Bag Sessions
Become a CHEOworks subject matter expert in our quick 30 min train the trainer series.
Click here to Register on the Online Learning Centre.
Questions?
Patients for Patient Safety Canada Perspective
Patient Safety Culture Bundle

Linda Hughes, Co-chair
National Health Leadership Conference, 2018
PATIENTS FOR PATIENT SAFETY CANADA (PFPSC)

• Patient-led program of Canadian Patient Safety Institute – since 2006
• Canadian arm of the World Health Organization PFPS programme - since 2006
• ~ 70 Patient/family volunteers from across Canada
• Every year ~ 100 requests for participation
  • Increasing requests to be part of committees to develop products, policies, practices rather than speaking engagements
  • Most at Canadian level
• Three of our members supported and participated in the development of the patient safety culture bundle
• We are very pleased that Patient/Family Engagement is reflected in all three aspects of the bundle
• The bundle complements the Engaging Patients in Patient Safety – a Canadian Guide
THE BUNDLE MATTERS

Why do we need tools like the Bundle and the document on Engaging Patients in Patient Safety

• We need to be honest with ourselves
• Despite all the best efforts of all of us

The 3rd leading cause of death in Canada is unsafe care
IPSOS SURVEY RESULTS

• Recent Survey of public commissioned by CPSI regarding patient safety
• In response to question “who is responsible for patient safety ?”
• 63% replied: leaders within health care organizations
TRUSTING PARTNERS

• So – we still have a lot of work to do TOGETHER.
• This work can be uncomfortable
• It begins with building TRUST and agreeing that patients and families can assist in improving our safety
• Part of trust building is to ensure that everyone has the same expectations about what engagement means

Theresa Sabo | TEDxStanleyPark
https://youtu.be/l3FkYdnc-FY
ENGAGEMENT SPECTRUM

Levels of engagement

- Direct care
- Organization
  - Service Design
  - Governance
- Health system
  - Policies
  - Priorities

Continuum of engagement

- Inform
- Consult
- Partner

Promise to patient

- "We will share information and keep you informed."
- "We will seek your input and ideas and provide feedback on how it influences decisions."
- "We will partner with you to address an issue and apply solutions."

Every patient safe    La sécurité pour tous les patients
2010 study by the Canadian Foundation for Healthcare Improvement investigated the benefits of engaging patients at all levels within the organization.

The study found that embedding patient in decision making structures within multiple levels of the organization will sustain real and ongoing patient engagement.

This Leadership bundle provides some structure about how to achieve this level of engagement.
ENABLING

• Establish a Patient Care Committee of the Board which includes Board members, Patient and Family members and which reports to the Board on a monthly basis

• Involve patients and families in the interviewing and hiring of senior positions within the organization

• A great example is the involvement of Patient surveyors through Accreditation Canada
ENACTING

- Review your visiting hours policies in hospitals – families are partners in care, not visitors

- Provide a means whereby families have immediate access to someone who can address the concerns they may have – example: posted phone number in every room of the hospital which can be called and will be answered 24/7.
• Involve patients and families in the design of processes to monitor and evaluate your safety and quality measurement.

• Another great example is the recent establishment of the HSO/CPSI Health Quality and Safety Advisory Committee which includes three patients from PFPSC and whose goal is to set priorities for required Quality and Safety standards.
CPSI AS LEADER IN ENGAGEMENT

• CPSI is an example of a leader who engaged with PFPSC from the beginning of its formation
• Together we showed that it can be done even in the most difficult circumstances - when there has been harm
• Took courage on both parts – our early members of PFPSC who were hurting and fearful and CPSI who worked with us through all the bumps and hard times
READY TO HELP

• Today, we are both stronger for our efforts

• PFPSC stands ready to provide assistance and support to those organizations who make a request from us to do so
• Involvement and Engagement of Patients and Families in all aspects of Health care decision making structures is crucial to moving forward on the safety agenda

• Patients and Families are the disruptive innovation that accelerates system reform

• Together we can improve Patient Safety